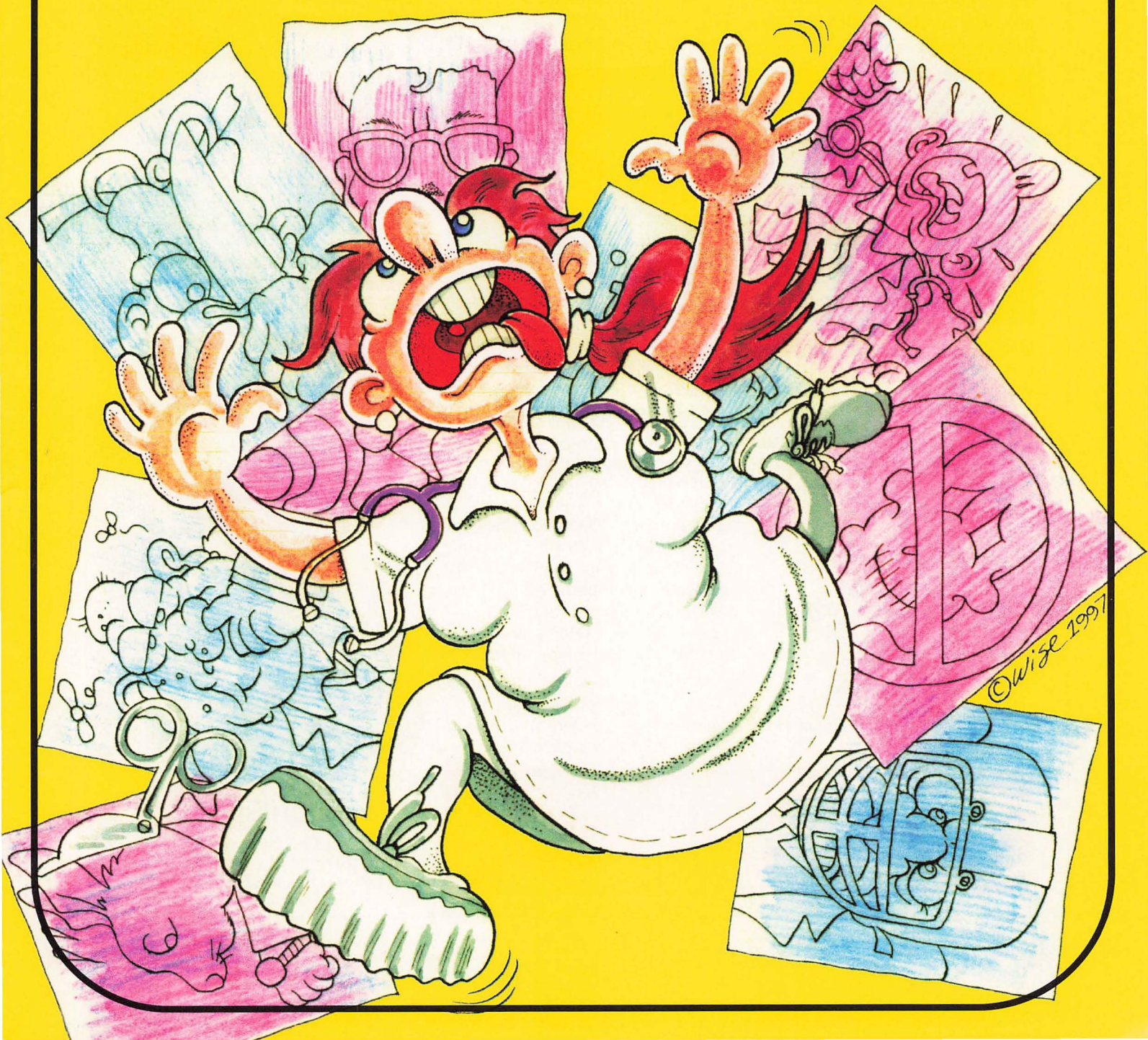
Aberrant Physician Types - Page 8

JOURNAL OF NURSING

Jocularity

The Humor Magazine for Nurses

Volume 7, Number 3 - Fall, 1997



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Journal of Nursing Jocularity® (ISSN 1055-3088) is published quarterly (February, May, August and November) by JNJ Publishing, Inc., 1815 W. 1st Ave., Suite 122, Mesa, AZ 85202. Periodicals postage paid at Mesa, AZ., and additional mailing offices. The Journal of Nursing Jocularity publishes humorous and satirical works in the fields of Nursing, Medicine, and other related disciplines. Send letters and manuscripts to JNJ, P.O. Box 40416, Mesa, AZ 85274. World Wide Web: http://www.jocularity.com

POSTMASTER: Send address changes to Journal of Nursing Jocularity, P.O. Box 40368, Mesa, AZ 85274.

To Subscribe: Send check or Money order (U.S. Funds only) to P.O. Box 40368, Mesa, AZ 85274. See ad on page 53. We are unable to start subscriptions with back issues. Your first issue may take up to 12 weeks for delivery.
Address Changes: Send address changes to Journal of Nursing Jocularity, P.O. Box 40368, Mesa, AZ 85274. Please include mailing label when making change of address or inquiring about your subscription. Allow 8 weeks for change of address to become effective.

Subscription Rates

USA	1 Year	2 Years	Canada , Mexico and Foreign	1 Year	2 Years
	$14.95	$25.95		$18.95	$29.95

Journal of Nursing Jocularity is indexed in the Cumulative Index to Nursing & Allied Health Literature. Printed in U.S.A.

MUSINGS
FROM THE EDITOR

Here's an e-mail that came in to the JNJ offices:

I was wondering if you feel that there is a different standard for managers and supervisors when it comes to initiating humor or participating in nursing humor. I work as a nursing supervisor and am a proponent of humor and its benefits to the nursing profession. I haven't been able to find any articles as of yet that address this. By the way, I love your web site and your magazine. Thank You!

Teri Gehring

And here's the message my boss, Publisher, Doug Fletcher, RN, responded with:

That is a great question! I haven't seen any research on that subject. My personal feeling, without putting too much thought into it, is that managers are always going to be held to a higher standard, be it humor or any other type of communication. You are going to have to be more in tune with what is appropriate and inappropriate humor. It sounds like you are in tune with some of the humor research. That is definitely a plus if you ever have to demonstrate to someone WHY you used humor in a particular situation.

Overall, I think a workplace is going to be much more productive with healthier communication if the managers use and encourage appropriate humor, while maintaining high performance expectations (i.e., "We are here to work, but we can have fun doing it"). If nobody has written an article or done research on this subject, it is definitely one worth exploring. I'm going to copy this letter to Fran London, my editor, and a couple of my contributing editors. The question might make a good article or editor's note. Thanks for the thought-provoking question. If you have any further thoughts on this, feel free to share them with us.

Doug Fletcher, RN
Publisher

I agree. I'd much rather work for a boss who can laugh. (And I do.)

I know of two articles on this topic:

Lee, B. S. (1990). "Humor relations" for nurse managers. Nursing Management, 21(5), 86-92.

Yura-Petro, H. (1991). Humor: A research and practice tool for nurse scholar-supervisors, practitioners, and educators. Health Care Supervisors, 9(4), 1-8.

Have you found others? Managers, what have been your experiences? Are you held to a different standard for humor than staff nurses? If so, how is it different?

Write or e-mail me with your anecdotes, research and opinions in this area. (Addresses on page 4.) If we get enough responses on the use of humor by nurse managers, we can compile them into an article.

Fran London

Fran London, MS, RN
Editor

Stethoscope:

Listening to our Readers

I was disappointed and even offended by the one issue of Jocularity I received. It's not only unprofessional, it's denigrating to both women and nursing.

Dalina Graham, RN
no address given

I am returning this magazine. I am embarrassed by subscribing to this awful magazine. I feel this magazine is an insult to nurses everywhere. This is supposed to be funny. I fail to see any humor in this magazine at all! Please cancel this subscription. I do not feel obligated to pay anything other than the first magazine which I am returning to you.

Janet Satterfield, RN
Villa Ridge, MO

Cancel this subscription! I was not aware that this poor attempt at humor was for the intellectually challenged nurse!

(indecipherable initials)

I discovered JNJ after it had been in print about two years. I immediately ordered all the back issues and have received every one since, as well. How surprised I was to note that an astute reader of yours wrote in to complain about the sexual connotations she found in some issues. I would like to ask what issues those were as I have been searching frantically for them. And I thought I had read every magazine from cover to cover!

Please let me know which issues to peruse again so that I might not miss out on one scintillating, disgusting, unprofessional, trashy comic-like word. I live for this stuff.

Kim Hopkins, RN, BSN, CCRN
Kingston, MO

I really love your journal. Perhaps this is what nurses really need. Working in Singapore as an RN. Personally, I think the Singapore Nurses lack the sense of humour. So do you know what I'm going to do? I'm going to subscribe to your magazine and share this with my nursing friends. I'm sure they will love it.

Sammy
via Internet

Hi! I just read "Step CPR" (Fall 1995, vol 5, no. 1) article in your Magazine . . . haven't had a belly laugh like this in years! We acute care med/surg and ICU nurses used to go out together after our evening shift and just trade humorous stories 'til we were rolling on the floor. It was a great (and much needed) stress reliever! Since then, I've worked in home care, where there is little opportunity for this type of camaraderie. Thank you for a heart-felt and spirit-lifting laugh! Your magazine just might help heal the healers!

Val
via Internet

Thank you for the wonderful conference. It went so well and I learned so much for the entire weekend.

I brought a mirth aid kit to work and everyone loved it. The nurse manager on my unit would like me to give an inservice on humor and healing. It sounds great and this conference has really gotten me excited about using humor at the workplace.

Clare McAnany
Oak Park, IL

First and foremost I want to thank you for the wonderful and excellent three day conference at Disney Hotel on May 30 to June 1st. I had come to work on a "humor high." It was wonderful to also network with other professionals. Just wanted to share that I use humor post it notes (appropriate ones) to make cover letters for faxing items. We all need a chuckle and laugh. Remember, a good laugh is less costly than an expensive face lift!

Wonderful job on the musical "Who's Got the Keys?"

Raisa Mironowski, RN
Whittier, CA

This is the first time I've read the magazine. It's wonderful. Myself, two very good friends and our boss went to see "Who's Got the Keys?" at Disneyland. After the show we

went to the Neon Cactus (a restaurant at the hotel) and here was all

the cast members of the show doing "Las Llaves." It was wonderful seeing the cast members having such a wonderful time. I don't think we will every think the same when we ask, "who's got the keys?" Thank you again for the great time. I'm going to subscribe the magazine right now.

Mary Bender
via Internet

Editor's note:
Clarification for those who did not attend our last conference: You missed the premier of the first musical comedy about nursing, "Who's Got the Keys?" Written, produced and performed by nurses. The show was so energizing, even after it was over the cast could not stop dancing. (Kind of like working one of those shifts that's hard to come down from.) But don't fret. You, too, can share in the excitement. See the Jocularity Catalog for your opportunity to purchase the music or the video.

You're so right about nursing humor being incomprehensible to most non-medical folks. I find I often cannot discuss things that go on in my ER even with my family. "Well! That just made me lose my appetite! Do you have to talk about that now!"

Yesterday at 6:45 am when my shift started I walked into a full arrest of a forty- something year old that didn't make it. What a way to kick-start the day! How do you explain how that feels to someone who has never seen someone die?

Sharon Pollock
Miami, FL

Just had to pass this little one along—I was dictating a note on a patient's chart yesterday and happened to see her medical history that she completed as a new patient. This poor woman wrote that she has "Reactive Airwaves Disease." What an affliction!

I had to turn off the recorder to give myself time to stop laughing, but then my thoughts ran wild. Is "Reactive Airwaves Disease" a case of sensitivity to radio programs? Problems with watching TV? Microwave difficulties? Inability to microwave? Hmmm . .

She also had a long list of psychotropic meds, so maybe her problem is hearing voices or noises? Or maybe this means she's one of those who picks up transmissions from the Pentagon or something.

Oh, the possibilities are endless, but I think some research is needed in this area.

Holly Biggs Garver, RN
Rochester, NY

I love the Journal of Nursing Jocularity. As a nursing instructor to students, I'm a big believer in humor, not only for the students but also for the clients. I hope to use some of the nursing student jokes to show my students that these wild and wonderful "things" do happen and you have to learn how to laugh at yourself and with others.

Thank you.

Teresa (Terry) Sherwood
via Internet

I happened upon the article "Romancing the CVP" (Fall 1994, vol 4, no. 3) as I was surfing the net in preparation for a report I am doing for nursing school on the images of nurses in the media. One of the prevailing themes is the idea of nurses as sex kittens.

Granted, many nurses are sexy and there is a preponderance of sexual humor in the medical workplace. However, to propagate this myth of the nurse as a female subordinate brainless bimbo who idealizes the male physician and interprets his medical skills in varying degrees of sexual prowess is a travesty. The struggle for respect and acceptance in nursing is not facilitated by such insults to the profession as "Romancing the CVP."

Kathleen Cochran
via Internet

I love the stories in this journal, especially "Romancing The CVP." I work in the OR and I can match up a doc with each type of CVP technique. Keep up the great stories!

Robin Stacy
Rochester, NY

I have been a subscriber since volume 1, number 1 was published and am not at all pleased with the change in advertising. First there was none, then some in back, then inserts, and now it is throughout JNJ. I really feel the advertising takes away from the articles. If you must have advertising for income, please make it less intrusive! Thanks.

R. Barall-Inman, RN, FNP
via Internet

Send your correspondence to: JNJ Stethoscope, P.O. Box 40416, Mesa, AZ 85274 or email to LaffinRN@Neta.com. We reserve the right to edit letters for length and clarity.

ABERRANT PHYSICIAN TYPES

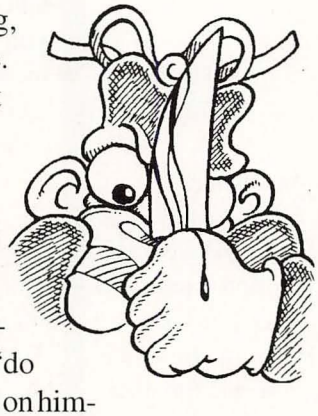
BY STEVEN J. SCHWEON, RN

I have almost fifteen years of clinical experience as a registered nurse. Every day I interact with physicians and muse about how I would get out of work on time if it wasn't for them.

After watching them in action, I've discovered most physicians are hard working, dedicated and caring individuals. Yet, there are those few who are aberrant. They exhibit behaviors that are strange, peculiar, and as they say in psychiatry, give you that "uh oh" feeling.

These traits often form patterns that are readily identifiable. Note that the more unusual characteristics a physician has, the greater the likelihood he or she will have a therapeutic misadventure.

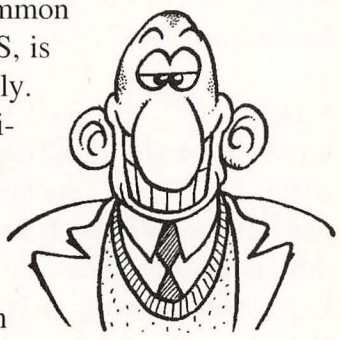
• Dr. "Slicer." This physician likes to cut anybody or anything, whether or not there is a pulse. He would be an excellent choice at a dinner party to help slice the meat. Unfortunately, regardless of the circumstances, his approach is to make incisions first and ask questions later. This surgeon needs to constantly "do something" and would operate on himself without anesthesia just for the thrill. Dr. Slicer is also known for cutting in on the dance floor.

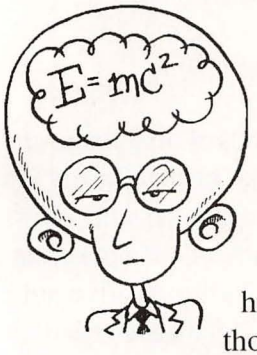


• Dr. "Shrink." This psychiatrist's practice is very state of the art and his own life is a shambles. In a therapeutic encounter with his patient, he may say, "You think your problems are bad? Wait till I tell you about my life. I can relate to your failure in relationships. I am going through divorce number three. I understand your need for alcohol. I numb myself with Scotch each night to cope with my unwed teenage daughter's pregnancy." Perhaps his motto is, "Do as I say, not as I do."

• Dr. "Death Will Never Win. Never." This physician cannot grasp the concept that all patients, despite medical technology, will eventually die. No matter how grim the prognosis, this physician insists on saving every life, no matter what the physical, emotional or monetary expense. "Hospice" and "DNR" are not in his or her vocabulary. This physician is deaf to pleas of patients, families and nurses. In the face of advanced disease process, crash carts are emptied. Every diagnosis requires controversial, experimental tests and procedures, and ultra-potent medications. This doctor plans to be frozen upon death, expecting to be thawed when a cure is discovered.

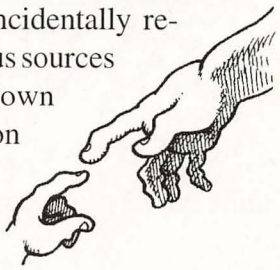
• Dr. "No Speak English." It is unclear how this physician, with so little understanding of the most common language spoken in the US, is allowed to practice clinically. Despite his or her intelligence, this physician cannot communicate either by the spoken word or writing. The hospital should furnish this physician with a personal interpreter.





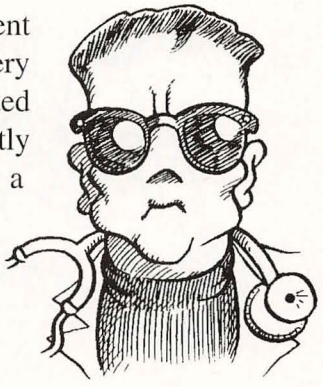
• Dr. "Brain." This physician has an extraordinary, off the scale IQ, yet lacks empathy and the interpersonal skills needed to communicate with patients and peers. He is awkward and uncomfortable in expressing his thoughts to living people. Perhaps his specialty should be pathology.

• Dr. "God." This doctor feels he is simply the best in the world, which coincidentally revolves around him. Anonymous sources claim that he calls out his own name during orgasm. He is on call to both the Notre Dame faculty and the Vatican. We should feel blessed to be around someone so important.



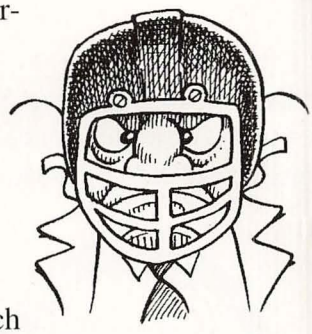
• Dr. "Ambivalent." Decisions are not this MD's strong point. This physician's specialty is vagueness and uncertainty. Thank goodness backup house physicians and smart nurses can get the job done. Another name for this physician might be Dr. "Analysis Paralysis."

• Dr. "Terminator." Every patient this physician contacts dies very quickly. It is well documented that the chance of death greatly increases when he walks into a room. Thus, this MD is forbidden to attend cardiac codes and resuscitation efforts. Perhaps his family owns a funeral home.

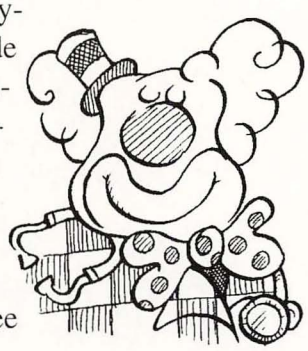


• Dr. "I'm On My Way." This physician is attracted to obstetrics. He or she is notoriously known for being late for the delivery of babies and being rescued by skillful obstetric nurses. This physician is also known for not sharing the wealth with his rescuers when it comes to the patient's bill.

• Dr. "Toddler." Rages, ranting and insulting behavior toward others distinguish this physician. Due to his poor attention span and limited self control, he wants things done yesterday. His temper tantrums send people running. His bravado is probably hiding his fear of incompetence.



• Dr. "Defensive." Characteristics of this physician include resistance to change, defensiveness, inflexibility and absence of team spirit. Unwilling to take risks, this MD lacks imagination and is quick to pass the buck when things go wrong. Which is often.

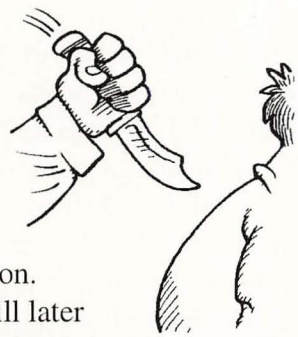


• Dr. "Shambles." This physician looks like an unmade bed. He wears awful combinations of colors and designs. Lord knows how he picks out his clothing and apparel. He has this problem because the drug companies do not give out free clothing to physicians.

• Dr. "Legal." Severe fear of lawsuits often paralyzes this physician. He or she ignores coworkers whose first names are "Sue." This physician will order every type of test available for a rule out differential of 100 diseases. Before lancing a small boil, this physician will order a type and crossmatch for six units of blood. Distributes "I will not seek legal advice" contracts to his patients before treatment begins.

• Dr. "Hypocrite." This obese, nicotine-addicted physician can be found hiding in the bowels of the hospital smoking cigarettes or eating to excess in the buffet line. He is a walking advertisement for premature death, yet he prides himself on his scare tactic teaching style.

• Dr. "Pus." Hospital wide infections can be traced back to this physician. Touches patients' wounds with his dirty hands and then can't be bothered to wash them. Has no concept of sterile technique, usually orders the wrong antibiotics, and simply cannot understand why his own patients develop nasty infections.



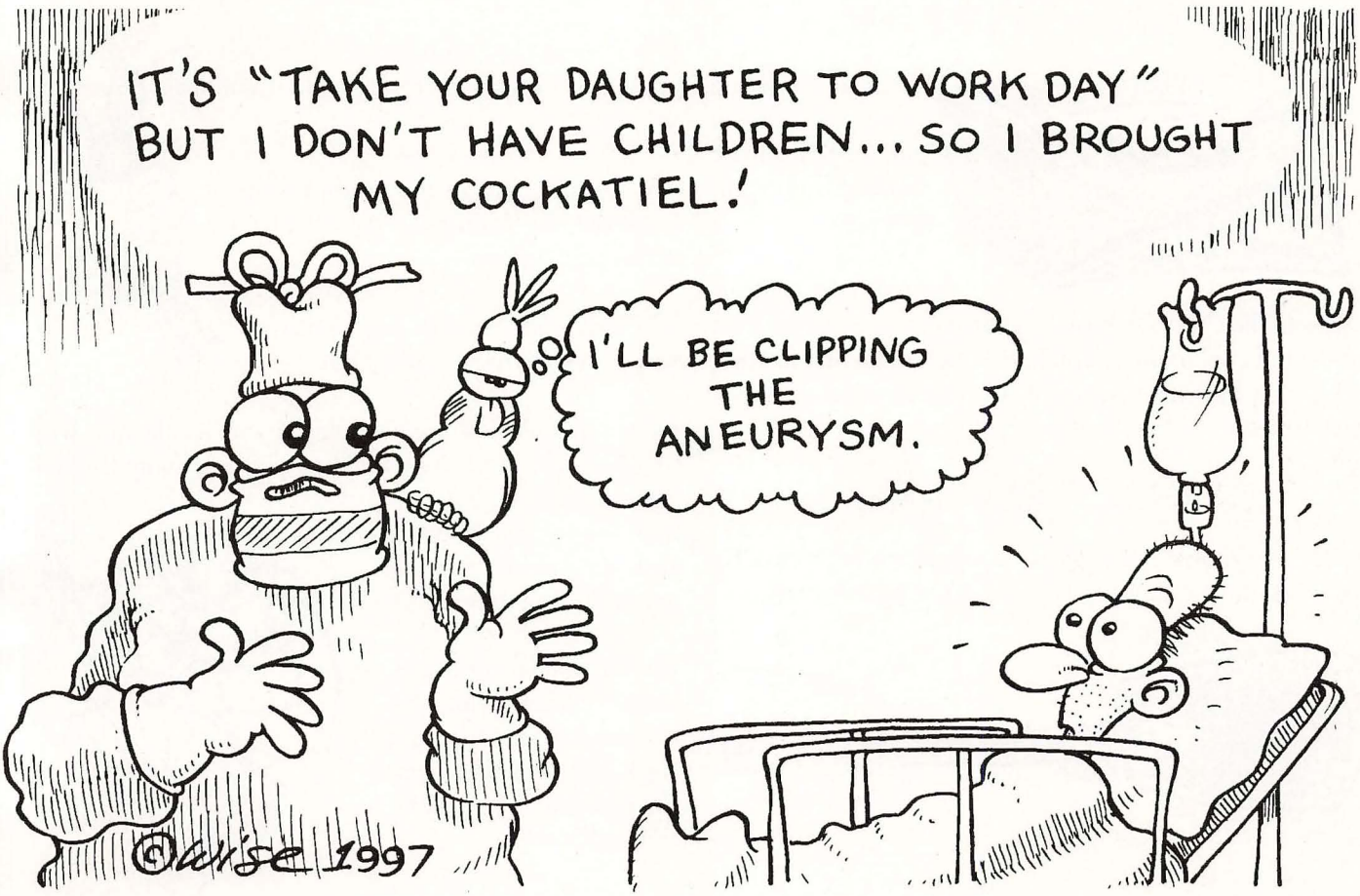
• Dr. "Kiss-up." This breed of physician is very quick to attack a peer behind his back. You might hear him say, "What an idiot, how did he make it past the first grade?" His critique will be loud and boisterous at the nurse's station. Yet, in sharp contrast, you will later observe these two physicians, with their spouses, dining out together having a meaningful dialogue and cracking jokes. Go figure. Tends to rise quickly in the hospital hierarchy.

These physicians are the sources of diagnostic and therapeutic misadventures. They inflict misery on everyone around them. They create everyday stress tests for their patients and coworkers. Proper treatment and healing are delayed. On the positive side, they inflate the medical GNP in added costs, secondary to their ineptness. And hey, they provide jobs for the health care industry and keep me employed.

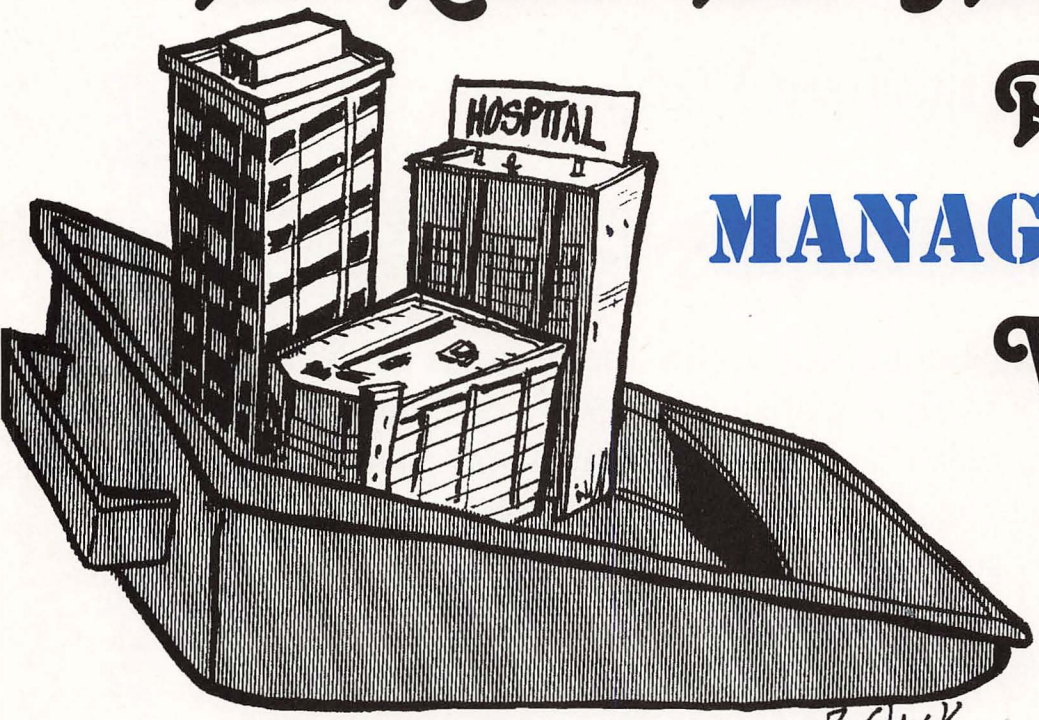
In Memory of

Andrea H. Sangrik, RN, BSNA

Andrea was a contributing editor for the Journal of Nursing Jocularity since it was first published in 1991. She had over 20 stories and articles published in the JNJ over the past 7 years, including: Real Reasons Nurses Call in Sick, Sucker School of Nursing, and Horo-scopy: The Horoscope for Nurses. Andrea died July 8, 1997. She was 32 years old. Her humor and wit will be dearly missed.

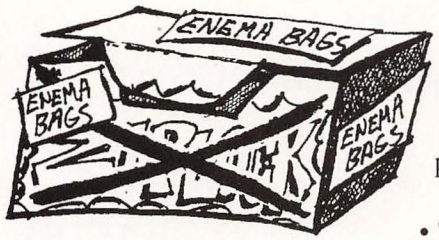


You Know Your Hospital Is Practicing MANAGED CARE When . . .



by Harold Stearley, RN, BSN, CCRN

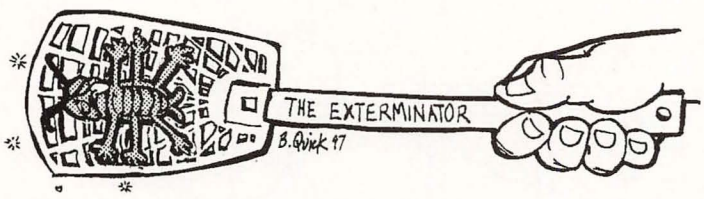
• The hospital's emergency generator is replaced with a stationary bicycle attached to a 12 volt battery.



• Upon ordering an enema bag you are given a Ziploc bag and told to improvise.

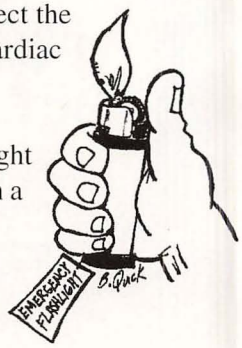
• To replace the batteries in the CCU's external pacemakers you are provided with a kit containing a lemon, two electrodes and instructions that are reminiscent of a science experiment you performed in second grade.

• The hospital's exterminator is replaced with two fly swatters and a rotation schedule for the patient units.



• Trash is now burned in the hospital's autoclave.

• As *Patient Care Coordinator* you direct the janitor in how to perform internal cardiac massage on your arresting patient.



• When the bulb in the unit's flashlight burns out, the flashlight is replaced with a disposable lighter.

• Double beds become an innovative way to reduce nurse:patient ratios.

• The Emergency Room is replaced with an elevator with four buttons: third floor for the operating room, second floor for intensive care, first floor for outpatient services and basement for the morgue. You decide.

• When an IV infiltrates, rather than wasting precious resources and restarting it, you switch to the new Subcutaneus Fluid Administration Protocol.

• Patient payments begin the day following their admission. Failure to pay the previous day's bill is an automatic discharge.

• All patients, regardless of diagnosis, are on the same twelve medications (the only ones stocked).

• "Take two aspirins and call me in the morning" becomes standard medical treatment. Even for trauma patients.

• Each inpatient is issued one styrofoam cup and one combination plastic spoon-fork, and then instructed that if they lose or break these, they will have to eat and drink with their hands.

• All surgical procedures are allotted two and one half hours of OR time. If not completed, administrative approval is required to schedule completion on another day.

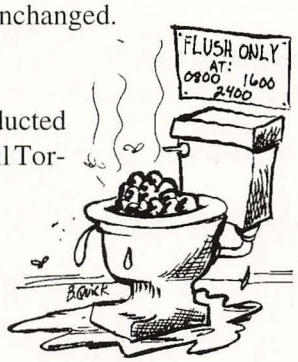
• Unused surgical instruments from one case are used on the following case. Used surgical instruments are cleaned in the pots and pans cycle of a dishwasher.

• The infection control department is replaced with a sign on the front of the building stating, "Danger: Superbug Crossing."

• *Universal precautions* for the nursing staff consist of a warning to maintain at least six feet of distance between you and your patients at all times.

• Dressing changes consist of flipping the old dressing over and re-taping.

• Hot water supply remains unchanged. There isn't any.



• Employee evaluations are conducted in the newly remodeled Mid-Evil Torture Chamber.

• Toilets and hoppers are restricted to a flushing schedule of once every eight hours.

• The "informed consent" form has been replaced with the "we are allowed to do whatever we want, bill you whenever we want, neglect you however we want, and you will like it" form.

• Biohazards are packaged in empty soda cans and taken to the local recycling center.

• All discharge planning and teaching plans are replaced with two words: Home Health.

• Oxygen, medical air and suction are all delivered through the same wall attachment.

• Managers have slogans posted in their offices, including:
"The only good staff is a reduced staff."
"Smiling is a sign of weakness."
"Bill first, treat later."
"Happiness is the sound of a cash register ringing."
"Even if you fired everyone, the quality of patient care wouldn't be affected."

• Construction has begun on the new Administrative Complex that includes a gourmet restaurant, racquetball and tennis courts, olympic-size swimming pool, casino, massage parlor, virtual golf course, horse racing track, stock exchange and gold depository.

• The hospital's risk management department has twenty-five new attorneys on staff.

• All administrative staff carry health plans where the care is provided at a different institution.

• The Medical/Nursing Library is bulldozed, and a vending machine selling *The Wall Street Journal* sits in its place.

Instructions for Nursing I Exams

by Brigid Nave, GN

Please read all instructions carefully before attempting exam.

1. If you are a recovering alcoholic, do not attempt this exam.

2. If you are carrying a concealed weapon, discard it immediately, then proceed with exam.

3. If you have PMS: Good! At least you have a fighting chance.

4. If this is your FIRST exam, take a moment and reflect. You are about to enter into the experience of a lifetime.

5. If this is your SECOND exam, you are likely to experience your first panic attack. This is normal. Just breathe deeply.

6. If this is your THIRD exam, you should have your coping mechanisms ironed out by now. Resort to them at this time.

7. If this if your FOURTH exam, you have already begun psychoanalysis. Research indicates feelings of inadequacy and stupidity are temporary. You should be able to resume your previous level of ADLs six to eight months after graduation.

8. Remember, the narcotic cabinet is kept locked at all times.

9. Prior to attempting the exam, assess your ability to remember your own name and the name of your significant other. If you find you cannot remember, don't panic. Quietly return your test to instructor and leave the room. You will find other nursing students in the hall with the same problem. Collaborate with them and all you will eventually recall your names.

10. If you have prayed for the assistance of God's angels during the past exam, don't lose faith. It's just that they don't know the answers either.

Some Helpful Hints:

• If you are sure you can reference the answer to a question, with author, page and paragraph, remember: it depends on the situation. You may not be correct.

• If you don't know the answer to a question, don't leave it blank. You're no worse off than if you did know the answer.

• On the questions that have two possible answers, choose either. You haven't developed critical thinking skills yet, so don't pretend you have. It just makes you angry when you're wrong.

• If you finish the exam and are pretty confident about your score, go back and change all your answers.

• If you hear a little voice in your head suggesting one of the answers . . . don't listen! It's just psychosis.

• Everything you ever needed to know about humility, you will have learned in nursing school.

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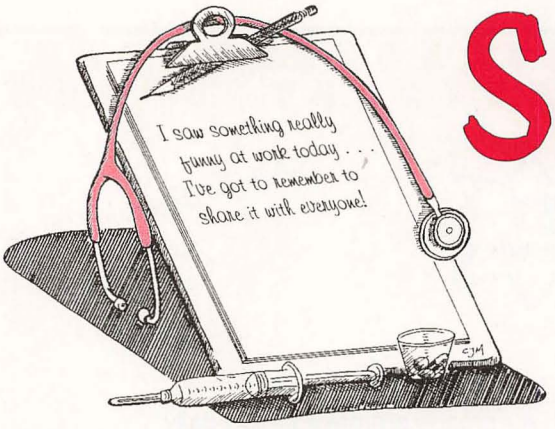
GINGER-RALE	Frothy, thirst quenching, ginger flavored rales.	$2.00



Stories From The Floor

Miss Information
Mary Clark, RN

A visitor approached the admitting clerk and asked, "Can you tell me what room my friend is in? He was in a fatal car accident."

Thinking the worst, I was prepared to usher him into the grieving room. The clerk, being more practical, looked up his friend's name and sent him on his way to visit him on the med-surg floor.

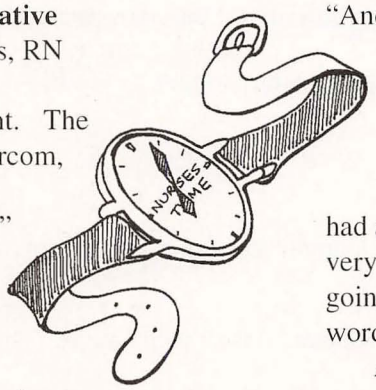
It's All Relative
Angie Fratus, RN

A patient rang his call light. The nurse answered through the intercom, "May I help you?"

"Can you come down here?"

"I'll be there in a minute."

"Is that a real minute or a nurse's minute?"



Old Timer's
Patricia Lamont, RN

I work in an extended care hospital and was doing an evening shift which required dispensing the supper time medications. Most patients receive something.

As a per diem, I did not know the patients well and was slower than the regular nurse. Realizing how behind I was getting, I began apologizing with each successive patient. As I came to the final one, she remarked on the time and I slipped into my routine apology adding, as I reached up to touch my white hair (I'm 62), "And I'm getting old."

She looked me up and down and stated quite clearly and with only a hint of a smile, "Honey, you ain't seen nothin' yet." She was 91.

Never Forget A Face?
Sharon Milligan, RNC

On my first visit to a new gynecologist, I told the nurse preparing me that she looked familiar. As I assumed "the position" on the exam table, it dawned on me where I had seen her before.

"You're the lady from my dog obedience school, with a German shepherd."

As I scooted down on the table and she peeked under the sheet to ensure the proper positioning, she exclaimed, "And you're the lady with the giant schnauzer!"

Loosen Up
Angela Lewis, RN

We admitted an elderly lady to our medical unit who had a secondary diagnosis of constipation. Since she was very hard of hearing, I had difficulty explaining that I was going to give her a suppository. She finally mumbled the word "suppository" under her breath and nodded.

After I inserted it she looked at me and said, "You mean you are just going to leave it in there?"

I nodded.

"Gee," she said, "I sure hope I don't have a BM!"

Fluid Folly
L. S. Howard

Mr. Seward, a delightful and pleasantly confused elderly gentleman, had general and penile edema. The assessing nurse asked when he noted the bulky penis.

"What? My penis is swollen? Glory me! Wonderful!" he exclaimed.

After furosemide therapy the edema subsided. Mr. Seward summoned the nurse, "I'm worried. Can you do something? It lost its shape, and shrunk too!"

Lower the Lid, Too

Tom Coss, RN

I used to work at a local ICU through the registry so regularly I became a de facto member of the team. One day, it was called to my attention that I was unaware of a specific policy change in the ICU.

The charge nurse challenged me on my ignorance, "Didn't you see the memo on the ICU bulletin board?"

"What bulletin board?" I asked.

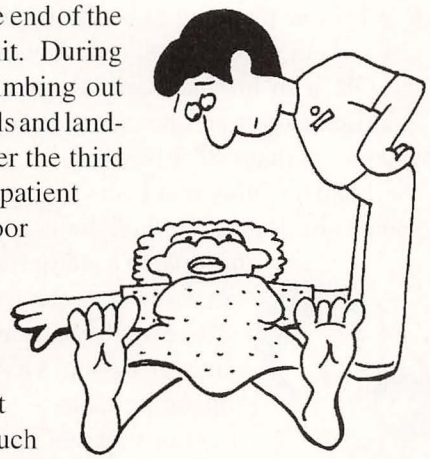
"The one in the bathroom."

I went to investigate. The bulletin board was about waist high, across from the toilet. You could only read it if you sat down.

What Call Bell?

Debra Lyday, RNC

There was an elderly little lady in the room at the end of the hall of a med-surg unit. During the night she kept climbing out of bed over the siderails and landing on the floor. After the third fall of the night, the patient was lying on the floor when the nurse rushed in.



She looked the nurse directly in the eye and said, "I just don't know how much more of this I can take!"

Bizarro Soylent Green

Kathy Carter, RN

Our hospital is a smoke-free environment. The only place staff can smoke is out back where, appropriately, the morgue is also located. One morning an orthopedic patient requested to be taken out to smoke. Jane, the CNA, took the patient out in a wheelchair to that designated spot.

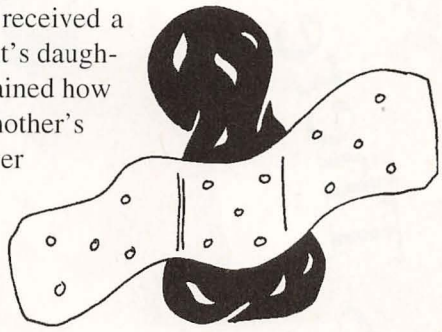
Minutes before report doctors were milling around the nurses' station, and the patient was still not back. I asked another CNA if she would help Jane bring the patient back from the morgue to his room, 115-B.

One doctor who overheard said, "Is the census so low that we need to recycle?"

Nihil Decubiti

Jennifer Gangemi, RN

One elderly home care patient was taking warfarin for a DVT. I instructed her family about the side effects of warfarin, especially bleeding, and to report any cuts to their nurse for observation.



Several days later, I received a phone call from this client's daughter. She frantically explained how she found a scab on her mother's leg. I instructed her to cover it with a Band-Aid and watch it for bleeding. I said I would visit the patient in a few days.

Sure enough, when I visited, there was a Band-Aid on her left shin. I carefully removed it and found a black scab. The client's whole family gathered around me, very concerned. Then a strange thing happened. The scab fell off into my hands, revealing white intact skin underneath.

Looking closely at the scab, I exclaimed "This isn't a scab, it's a raisin."

The client scratched her head and confessed she had raisin bread for breakfast a few days before.

Diversionary Activity or Diversion

Fran London, MS, RN

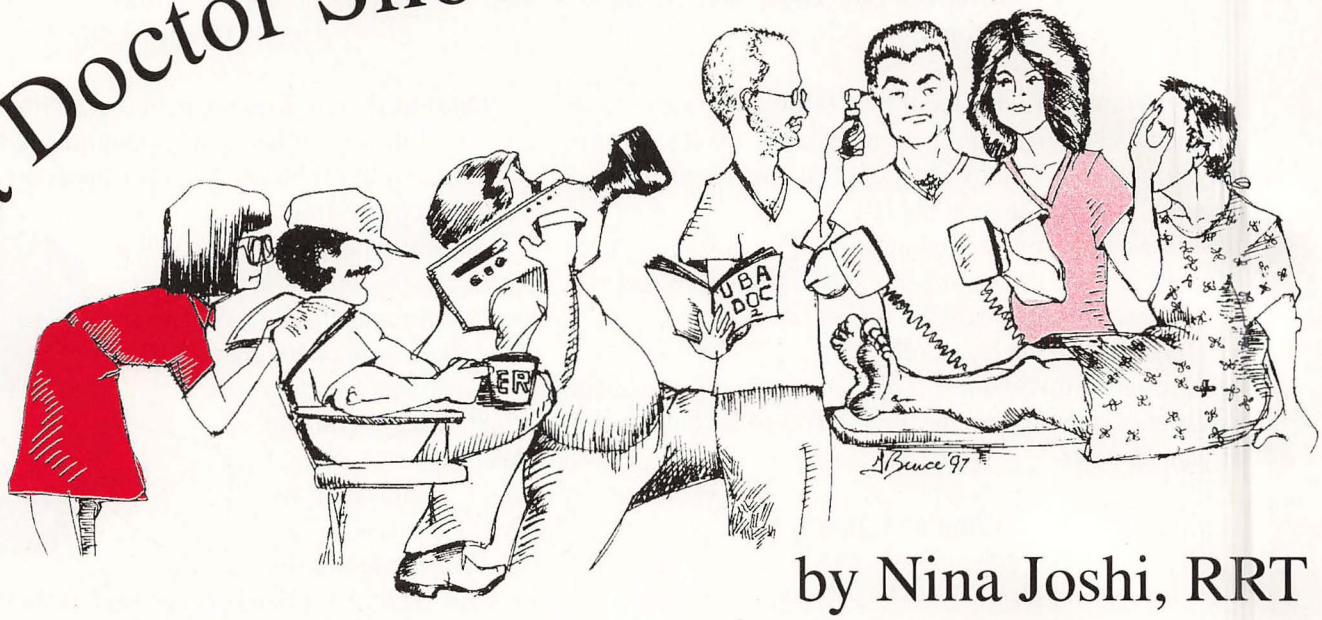
Mark was born with one ventricle. He spent much of his childhood in and out of hospitals.

This time he was in with fluid overload. He was sneaking so many drinks we had to lack his bathroom door. He protested, but finally settled down to play. He decided to be artistic and set up his paper and paints.

It seemed innocent, until he asked me to "fill this cup with water for my paints. Very, very cold water, please."

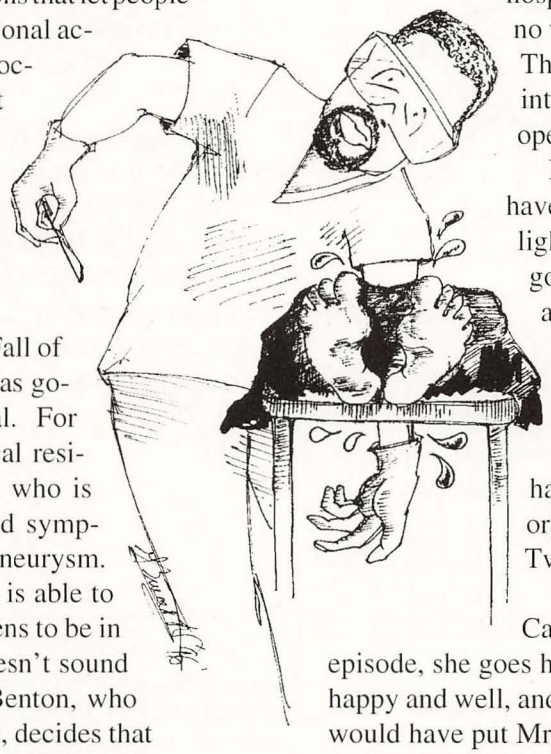
Stories From The Floor is a regular feature in the JNJ. Send your funniest true stories (50 to 200 words) to us at JNJ SFTF, Mark Darby, RN, 2917 N 49th St., Omaha, NE 68104. If we use your story you will get 2 copies of the JNJ with your story, and an exclusive JNJ T-shirt.

Is There a Doctor Show in the House?



by Nina Joshi, RRT

Perhaps the endless string of medical jargon impresses the viewing audience of the show *ER*. Whatever it is, this program is the number one dramatic series in the nation. If you watch carefully, you will notice that much of the show's dialogue involves the names of tests, and the doctors and nurses reel them off as fast as you can down a cup of alphabet soup. CBC, MI, ABG, EKG and BP are just a few delightful letter combinations that let people know they are watching professional actors acting like professional doctors. But the medical word that every lay person needs to know, to be medically literate, is "STAT." Immediate tests sound rather impressive, unless you hear them day after day in a real-life hospital.



From *ER's* premiere in the Fall of 1994, I couldn't believe what was going on in this large city hospital. For example, a brash, young surgical resident, Dr. Benton, has a patient who is suffering from all the signs and symptoms of an abdominal aortic aneurysm. The only vascular surgeon who is able to perform the operation just happens to be in the Caribbean. Now, if that doesn't sound scary enough, there is more. Benton, who has never performed the surgery, decides that he has enough book knowledge to figure things out. So, without any further hesitation, he starts the procedure without the aid of a fully staffed and qualified team. I guess Benton was planning to be the scrub nurse, anesthesiologist and chief surgeon all rolled into one. He just stands in the OR with his hands in this poor man's guts, until a qualified expert can be called in from God-only-knows-where—perhaps St. Elsewhere.

I had a feeling that I was seeing surgery performed in some rural Russian village, rather than a major teaching hospital in a major American city. There is no vascular surgeon in hospital or on call? There might well have been goats walking into the ER and a haystack as the patient's operating table.

If this patient had any sense, he would have made a quick dash down the bright-lighted tunnel, because the chances were good that if he survived Benton's learn-as-you-go operation, he might never have been a productive citizen again. Who knows what kind of cutting Dr. Benton was doing inside that human guinea pig? In fact, Benton is so surgery-happy that he might as well have done an organ transplant, too. What the heck. Two for the price of one.

And how am I to trust the star nurse, Carol Hathaway? Halfway through an episode, she goes home at the end of her shift, seemingly happy and well, and downs a dump-truck load of pills that would have put Mr. Ed in that big barn in the sky.

With Carol on the verge of death, the ER team rallies together to save one of their key players. They place a tube down her windpipe, hook her up to life support and pump

her stomach. Of course, Nurse Hathaway miraculously pulls through, without any ill effects. A couple of episodes later she is back to work, smiling and talking about getting married. It wasn't until over halfway through the season that the audience learns she had been in therapy. This was good, because I was wondering if she should be walking around with the keys to the narcotics cabinet.

I guess a lot of the workers in this television hospital suffer from depression. In one of the earlier episodes, the show's psychiatrist stands in the center of a busy highway, on Thanksgiving Day, in the pouring rain, and hopes that a car will run him over. If he's Nurse Hathaway's therapist, that would explain a lot of things. Of course, he seems fine now, and I hope he is getting some needed therapy. Or perhaps Dr. Benton will specialize in psychiatry, too. Then he can suggest lobotomies for all his troubled patients.

Don't get me wrong. Dr. Benton has begun to grow on me. He has just the right amount of top-gun arrogance to make him a believable surgeon. And I have to applaud the network for giving high-powered roles to minorities. In the case of St. Elsewhere and Doogie Howser, minorities played good-humored orderlies or janitors cracking jokes and sprouting Rastafarian hairdos. I used to think these characters were some figment of a white writer's imagination. And thank God that the nurses are not like the nurses on Howser who seemed just to sit around in the cafeteria and give love and relationship advice to the hormonally awakening Doogie. They have valuable input, make quick decisions and illustrate that a hospital doesn't work on just doctor power alone, as was the case in St. Elsewhere.

Thanks to a lot of consulting with actual doctors and nurses, the top-rated medical show of the 1990s has become much more plausible since its first few months on television. And, after all, a hospital dramatic series is just that: it is drama with actors. For many of us who work in hospitals, it is sometimes difficult to abandon our work roles at home. Perhaps that is why so many health-care workers, including myself, religiously watch *ER*. You would think we would have seen enough blood squirting from people's aortas, and human limbs being carried into the ER by paramedics.

Well, some of us see a little less action. But who is going to write a show called Bedpan Alley? Or COPD Blue? I guess it is just the kind of adrenaline that keeps us getting up at five-thirty in the morning, or has us eating dinner in the middle of a graveyard shift in a hospital cafeteria.

Well, I have to be going now. It is almost ten o'clock on Thursday night, which means I am needed in front of my television set—STAT!

Questions

Carol Cramer, RN

I have questions. Questions that keep me up at night. Questions that keep me wondering, contemplating, desperately trying to understand. Sometimes when I dream, the answers come to me. But as I wake, the answers are gone, snatched up like gastric contents hooked to wall suction. Questions like:

Why do patients ask if a shot is going to hurt?

Why do parents ask if their child's gaping four-inch laceration is going to leave a scar?

Why do people have rides to the hospital, but not home?

How can people get in the car by themselves, but not be able to get out when they arrive at the ER?

Why do men having heart attacks come in by car but women with yeast infections come in by ambulance?

Why can people dress themselves at home but not in the hospital?

Why is it every time nurses plan a party and bring food to work, it gets crazy, but every time administration walks through, it is quiet? Why don't we page administration when it gets busy? Are we too busy?

Why do patients wait until you stick them three times before they tell you the other arm is the only one with veins?

Why do patients who lose their wallets always carry $4000 cash?

Why don't parents give their febrile children Tylenol?

Why do people come to hospitals they say they hate?

Why do patients blame a hole in the "odorzone" for their sunburn?

How do people who have never had sex get pregnant?

Why do teenagers say they don't want to be pregnant but they won't use birth control?

Why do people with blood alcohol levels of 400 say they only had one beer?

Why do people not have money to fill a prescription for amoxicillin, but they have money for cigarettes and happy meals?

Why do patients always turn towards the nurse's face before they cough or vomit?

Why is it people who need surgery have always just eaten?

Why do patients always lose their prescriptions for lorazepam and codeine, but never their prescriptions for antibiotics?

Why are all drug addicts allergic to antiinflammatories, Nubain and Stadol?

Why do overdose patients yell at me for lavaging with charcoal because "charcoal is a carcinogenic?"

Above all, I have a question about hot dogs. Why do so many people eat hot dogs before they overdose? Why don't they chew? Do hot dogs taste so bad people can't leave them in their mouth long enough to chew them? Is it the taste that drives people to attempt suicide?

What is a hot dog made out of anyway?

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Manipulation and deceit keep hospitals in power and nurses disenfranchised.

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What the government isn't telling nurses about AIDS is what the hospital isn't protecting them against.

DANGER - Hospitals At Work
Ongoing features exposing dangers in the clinical setting. Reporting hospital violations to OSHA and JCAHO

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We will keep you updated on the bills and legislation in Washington D.C., and their impact on the nursing profession

FLOATING
Nurses object to being pulled from their areas of expertise to care for patients on units where they have no experience. Some who protest are being listened to; others are being fired. Some legal advice on what to do about it!

WHY DOESN'T A SMART GIRL LIKE YOU GO TO MEDICAL SCHOOL?
"You're just a nurse!" is one expression nurses have heard too often. A feminist awareness can brighten this dark picture.

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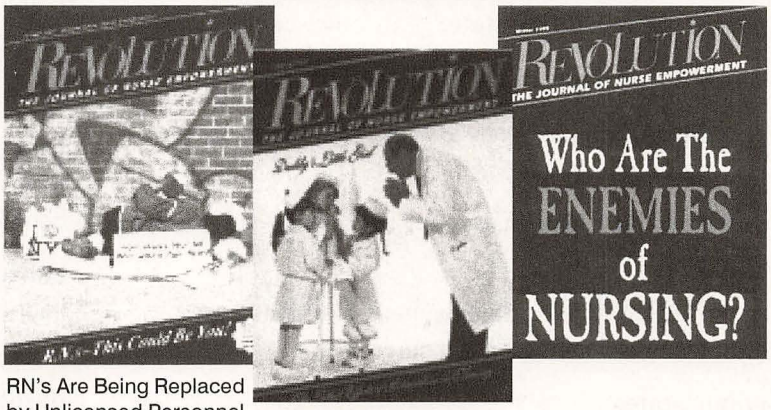

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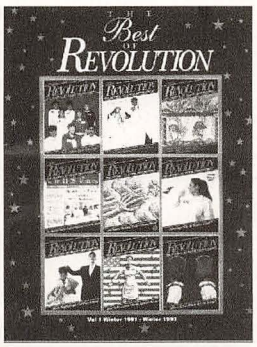

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Applied Pediatrics

by Christine Stephens, RN

Most nurses are also Moms or Dads. The art of parenting has so much in common with nursing that sometimes it is hard to tell if you're at work or at home. However, many disorders you encounter at the hospital take on new meanings when you're raising a pack of kids!

insomnia: kids on a school night.

persistent vegetative state: kids on a school morning.

status epilepticus: a prolonged temper tantrum.

polydipsia: this happens to kids ten minutes before leaving on a long car trip.

polyuria: this happens to kids ten minutes after leaving on a long car trip.

hypertensive crisis: this happens to kids twenty minutes after leaving on a long car trip.

manic state:

1. kids thirty minutes or more after leaving on a long car trip. This commonly persists for the rest of the trip.

2. kids two minutes before the school bus arrives.

3. teenagers before going out on a date.

congestive heart failure: your teenager after breaking up with her boyfriend.

bipolar disorder: teenagers in general.

dumping syndrome: what all kids do with their coats, hats, boots, shoes, socks, backpacks and homework upon arriving home from school.

polypharmacy: when your kids have too many pets.

amnesia: what happens to kids whenever Mom demands to know who draped the dirty sock on the lampshade. (see also: denial)

lethargy: kids assume this state whenever there are chores to be done.

stupor: kids assume this state after playing video games for four solid hours.

hyperglycemia: kids on Easter morning, Halloween night and after visiting Grandma's. (Everyone knows this one!)

hives: what kids like to throw rocks at.

kwashiorkor: what Grandma is convinced your kids have and that she is compelled to treat with homemade cookies just before dinner.

anorexia: your kids after eating Grandma's cookies, and just as they sit down for dinner. No wonder they have Kwashiorkor!

dysphagia: appears whenever a kid has to swallow a pill, liquid medicine, broccoli, or liver.

disuse syndrome: the state of your kids' school books.

denial: what happens when Mom or Dad demands to know who made that mess. (see also: amnesia)

visual floaters: these occur whenever Mom and Dad try to have a conversation as kids drift in and out of the visual field in a effort to attract attention.

akathisia: a child's overpowering urge to jump, run and do cartwheels during a time when he or shee must sit quietly for a while (like in church, school, dinners in restaurants, funerals, weddings or waiting rooms).

selective hearing loss: occurs whenever Mom or Dad announce there are chores to do.

code brown emergency: another thing that happens during long car trips.

multiple trauma: this occurs after your standard sibling rivalry disputes.

spontaneous remission: occurs at sound of the ice cream truck.

Top Ten Ways to Know You Are an ER Nurse

complied by Debbie Davis, MS, RN

1. You believe "shallow gene pool" should be a recognized diagnosis.
2. You believe unspeakable evils will befall you if someone utters aloud the "Q" word, "Wow, it's really quiet."
3. You have the bladder capacity of five people.
4. You have looked at a total stranger and said to yourself, "great veins!"
5. It seems perfectly normal to discuss dismemberment over a gourmet meal.
6. You believe the size IV catheter you choose should be directly proportional to the amount of ETOH on board.
7. You've ever had someone say to you, "I have no idea how that got there."
8. You have ever asked a patient with a sore throat, "And why did you not go to the clinic today?"
9. You believe bad things, especially cardiac patients and deaths, comes in threes.
10. You believe in the power of the full moon.

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Call Lites!

The JNJ Joke Collection

Question: What do you call a marriage between two doctors?
Answer: A paradox.
Submitted by Kerri Lynn Hilbert, RN

Question: What does a doctor mean when he says, "Good thing we caught this in time!"
Answer: He means, "If you waited another week it would have cleared up by itself."
Submitted by Gary Hermus, RN

An old man tells his friend, "I've got my health, everything is fine. My heart is good. My liver is good. And my mind, knock wood . . . who's there?"
Submitted by Jennifer Bowan, RN

In medicine nowadays, only germs can hold onto money.
Submitted by Adrian C. Allen

What did the nurse mean " No Deposit, No Returns!"

Welcome to the Psychiatric Hotline:
If you are obsessive-compulsive, press 1 repeatedly.
If you are co-dependent, please ask someone to press 2.
If you have multiple personalities, press 3, 4, 5, and 6.
If you are paranoid-delusional, we know who you are and what you want. Just stay on the line so we can trace your call.
If you are schizophrenic, listen carefully and a little voice will tell you which number to press.
If you are manic-depressive, it doesn't matter which number you press. No one will answer.
Submitted by Ellicia Cloud, NA

MENtaI breakdown, MENopause, MENstrual cramps, MENtal fatigue . . . lots of women's problems begin with MEN.
Submitted by Dorothy Stauffer, RN

Schizophrenic to psychiatrist: "Where am I when I need me?"
Submitted by Harvey Cholfin

"Doc, I think my wife is going deaf."
"Try this: Stand a few feet away and ask a question. If she doesn't answer, move closer. Keep doing this until she answers to get an idea how hard of hearing she is."
The man went home and walked in the door, calling out, "Honey, what's for dinner?"
No answer.
He moved closer and tried again. Still no answer.
He did this three times until he was right next to her.
"I said, Honey, what's for dinner?"
"For the fourth time: Meatloaf!"
Submitted by Sandy Ritz, DrPH, RN

Question: Why do surgeons wear gloves while operating?
Answer: So they won't leave any fingerprints.
Submitted by L. S. Howard

There ain't much fun in medicine, but there's a lot of medicine in fun!
Submitted by Josh Billings

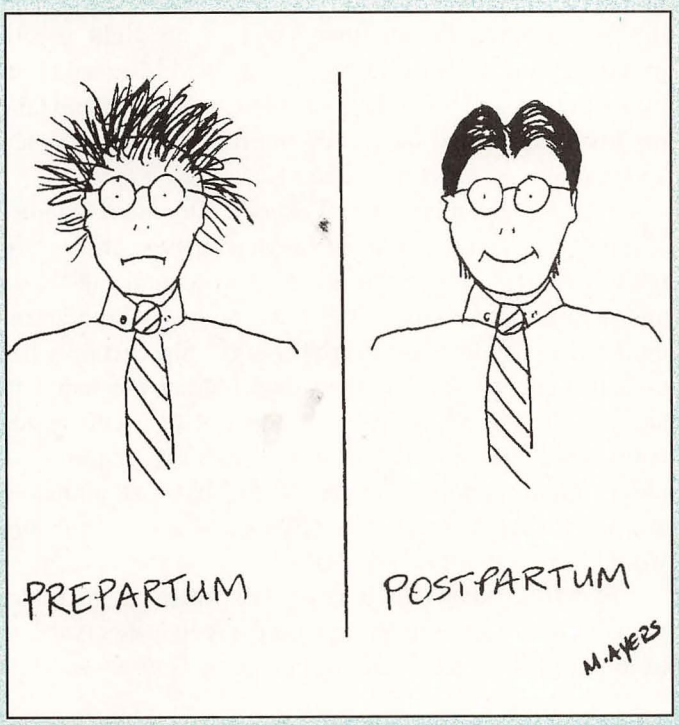
A student nurse took a driver's test and drove through a red light.
"Young lady," said the trooper accompanying her, "what does a red light mean?"
"A bedpan."
Submitted by Dorothy Stauffer, RN

Question: How many doctors does it take to change a light bulb?
Answer: It depends. How much insurance does the light bulb have?
Submitted by Alicia Brown, RN

There was a young man with a hernia
Who said to the surgeon, "Gosh dernia!
When carving my middle
Be sure you don't fiddle
With matters that do not concern 'ya!"
Submitted by Lester Gottlieb

Mother: "Here's your medicine."
Child: "You're practicing medicine without a license."
Submitted by Marsha Duren

Before psychiatric treatment, a neurotic was afraid to answer the phone.
After treatment, he answered whether it rang or not.
Submitted by Donna Goldman



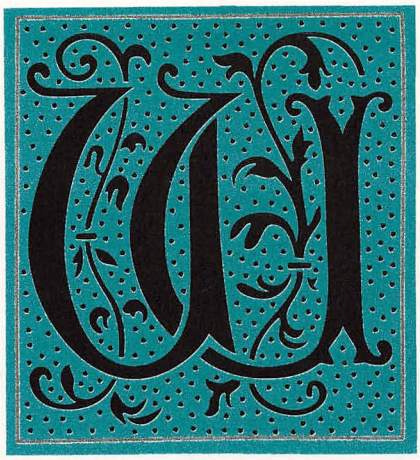
Nurse: "When is your birthday?"
Patient: "June 10th."
Nurse: "What year?"
Patient: "Every year."
Submitted by Anna Nicholas

A man thought he was a bird.
After psychiatric treatment, you never heard a peep out of him.
Submitted by Henrietta Singer

Surgeon: "Never mind the sponge count! Where are my contacts?"
Submitted by Carol Clark

Patient (yelling out of the waiting room): Doctor! Help! I'm shrinking!
Doctor (from inside his office): I'm busy. You'll just have to be a little patient.
Submitted by Debbie Davis, RN

Heard a funny nursing or medical joke lately? Send it to us! If we use it in Call Lites, you will receive 2 copies of the JNJ and a Limited Edition JNJ T-Shirt. Send your jokes to: John Baringer, JNJ Joke Editor, P.O. Box 2221, Tucson, Arizona 85702-2221.



omb Service, Please

by Janet Rosen, RN, BSN, PHN

Going for surgery, even (or especially) when one is a nurse is quite odd, and not recommended. People thought my responses to an upcoming hysterectomy were peculiar.

Then again, nurse or not, my brain doesn't seem to follow the same cognitive leaps as most people's. A few years ago, when my sister told me her husband was going to have a vasectomy, the very first sentence out of my mouth was, "Well, I will just have to make him a sperm pillow to hold onto while he deep breathes and coughs." (And I did, a lovely black velvet one, with a black damask tail and gold button eyes and gold braid trim.)

So while my gynecologist was talking about incision lines, my thoughts were on a pink plush uterus, lined in quilted satin, with removable chenille fibroids. Then I went home and did some serious thinking. About a piñata shaped like a uterus, filled with the things fibroids are as large as (grapes, golf balls, grapefruits, whatever), and a party where all my female friends and I whacked the hell out of it with a stick. You get the idea . . .

But the date for surgery was set and it was time for some serious coping mechanisms to kick in. Since I'm compulsive, I got very organized. I had lists of what foods to stock up on and lists of what foods I had bought. Lists of what art supplies and books to have on hand during convalescence and lists of which had been obtained. Lists of who has offered to do what and when they might do it. I briefly considered a list of what lists remained to be done.

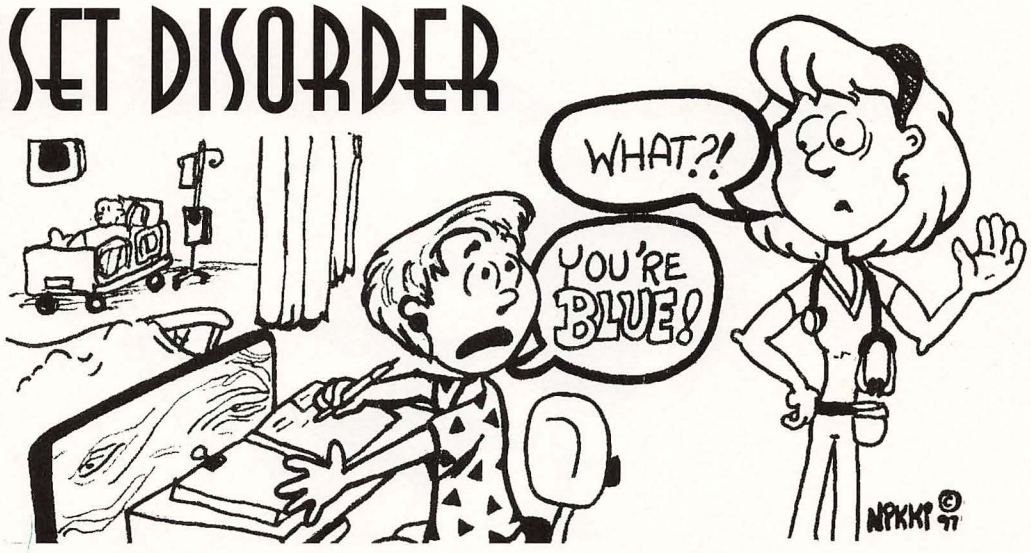
Then in surgery, the doctors encountered the Amazing Exploding Ovary. The plan was to keep the ovaries, but one of them apparently didn't like being looked at and decided to go ahead and rupture. This started some arterial bleeding, so out it came, leaving its twin to do all the work. This permitted me, upon my arrival home, to answer the phone languidly, "Madame Ovary, at the Hotel Des Invalides."

Cutting through the abdominal wall means no abdominal muscle tone. Everything just sort of sloshes, like in a wineskin. Every time I stood up it felt like my abdomen and all of its undisciplined contents were going to fall right down to my knees. This was not compatible with cheerful, whistling strolls up and down the hall, which, unfortunately, are precisely what you need to do at all hours of the day and night, in order to, ahem, pass gas. The now toneless tummy did an impression of an eight month pregnancy and it hurt. I slept upright with a bolster and four pillows under and around me so that I could get up and take my lovely nocturnal walks without flailing about the bed and waking my husband with curses, sighs and yelps.

There is also the matter of energy. Do you remember learning, back in pre-nursing science classes, about "potential energy?" A person who has had general anesthesia and major abdominal surgery must be considered an incredible repository for potential energy. She certainly has no actual energy. The first few days home I was happy to sit. Or lie. Reading the newspaper with a cup of tea constituted the morning exercise sessions, requiring a ninety minute nap for recovery. I could have sat, unmoved and unmoving, through a sizable earthquake. Probably would have put it down to gas!

Everyone says that it takes six weeks to feel like yourself after this surgery. I would say that this is a rare example of everyone being right.

NURSES UNRAVEL THE MYSTERY OF CLOSET DISORDER



BY DIANNE BROWNSON, RN

A nurse friend recently commented that uniform sizes are so inconsistent, it's nearly impossible to find a decent fit. After buying a new set of scrubs, the same size she'd always worn, she found they cut off her circulation and made her short of breath. She volunteered this information because, although I tried to look away, I was staring. I had never seen her eyes bulge before, and she wasn't usually blue.

I told my friend I didn't think the problem was with the manufacturer, but some sort of closet contamination. Some mornings I've observed the same phenomenon myself. I had clothes that fit perfectly the last time I wore them, but after putting them in the closet, they became a size or more too small. In fact, the longer they hung in the closet, the smaller they got.

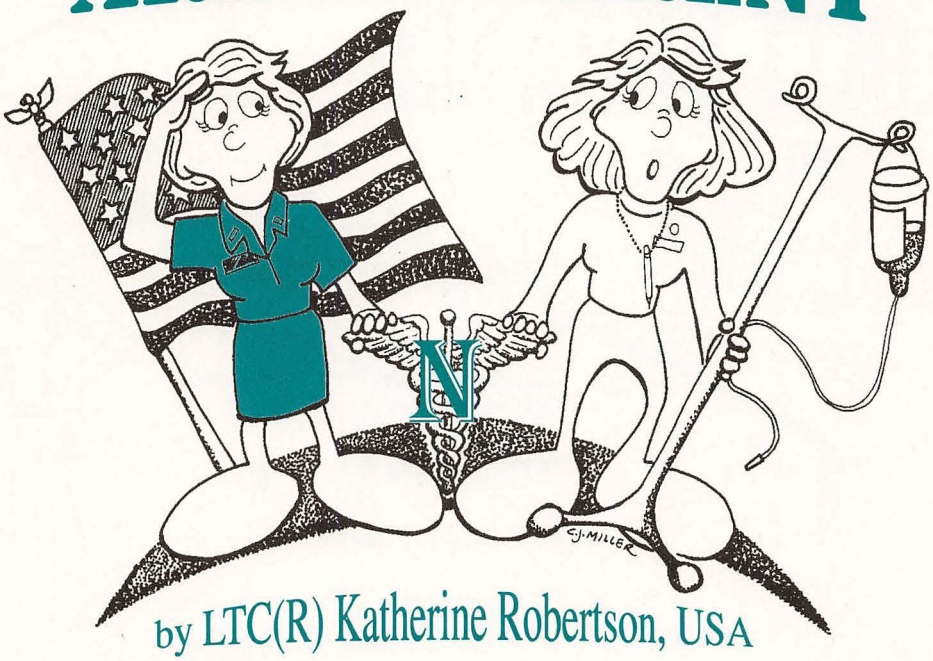
This realization appalled us. We remembered how many times we had mistaken these symptoms in our patients as signs of pulmonary problems. Of course they pinked up with supplemental oxygen! At the same time, we removed their clothes! We were on to something new. I've never seen a study on the effects of closet contaminated clothes and oxygenation.

At first we weren't sure what to do with our scientific breakthrough. I had my hand on the phone, ready to call the CDC, when my friend stopped me. What if some evil dictator learned of this discovery? It could lead to closet contamination warfare. We had to weigh our desire to win a Nobel prize against our fear of closet proliferation.

After much discussion, we decided to conduct a study on the incidence of closet contamination syndrome, as we're now calling it. My own sister has a severe case, which has its most noticeable impact on her jeans. She's gasping so loudly, she can't even talk. Maybe there's a familial susceptibility to the disorder.

After we complete our research we can formulate a plan for action. We need to optimize the peaceful applications of the implications of closet contamination. Then we'll pick up our Nobel Prize.

HOW WE IN THE MILITARY ARE DIFFERENT



by LTC(R) Katherine Robertson, USA

Since I'm a contributing editor of *JNJ,* I was asked to contribute a humorous article about military nursing. Since I have been in the Army for eighteen years, it would seem that I am an appropriate person to do this. But can I write anything about the Army that you, as civilians, would find funny? There was a time that in this country that the military, particularly the Army, was a shared experience. But with the demise of the draft and the advent of the all volunteer force, large segments of our country have no contact with the military. There is a lot of humor in uniform. But unless you speak the military language or understand the peculiarities and idiosyncrasies of the system, you won't get the jokes. So first I need to provide some basic information about the Army so that you can understand the difference between you and us.

Rank: The Army has a ranking structure. You come in the Army as a young, inexperienced Second Lieutenant (2LT) otherwise known as a "butter bar" because your rank insignia is a gold bar that actually looks like a stick of, well, butter. You then work your way to Colonel otherwise know as "bird" because the insignia is an eagle. How does the rank structure affect us? Well, I was absolutely amazed at a recent letter in a nursing journal where a nurse discussed the problem of a physician cursing and throwing things at the nurses in the work site. Could that happen in the Army? Well, let's say that a physician (Captain) walks into the nurse station and decides to take out his bad day on the nearest object, which happens to be a Second Lieutenant Nurse. What would be the result?

Well, nothing, because it wouldn't happen. No one picks on 2LTs. It would be a cruel dastardly act and the result wouldn't be worth it. All coffee and baked goods would be off limits, not to mention that you would be ostracized for months. You want an NG tube passed? There's the supply closet. Enjoy. Second Lieutenants are fragile little beings. It takes them months to get over the fact that the Army isn't exactly like the M.A.S.H. television show that they watched for years every day after school. They are still in shock because they asked to be at major medical center in Hawaii and aren't there! If they went through R.O.T.C. they are in shock because they view the Nurse Corp as "so lax compared to their old units." They want to be out in the woods foraging for food and evading enemies. They want to give nursing care in a tent not in a hospital. No one picks on 2LTs. It would be too mean.

Well, what if the nurse happens to be a 1LT? Not a good move. First Lieutenants are tough, and they are the work horses. They have experience. Mess with a 1LT and that head nurse will be all over you like white on rice. No, it would never happen.

Well, what if the nurse happens to be a Captain? Now we've got equal ranks. Very interesting. Let's say the CPT Physician flings a chart and it hits the Captain nurse. Well, assault on a fellow officer is a dishonorable discharge. Of course the Captain nurse does have the option of throwing the chart back. Or defending himself with the hot cup of coffee he's holding. Or he can duck and let the chart hit the Major standing next to him.

The Captain is now fried. Assaulting a senior officer? That little Captain better make a quick trip to the nearest psychiatric ward and start pleading temporary insanity. Now, if the Major happened to be Lieutenant Colonel the Captain might as well just stand there with his arms hanging out waiting for the Military Po-

lice (M.P.s) to put the handcuffs on him and lead him away. We are talking definite change of duty station to the Midwest, Fort Leavenworth, "oh yes, this does look like Kansas Toto," home of the "there's no such thing as parole" Military Prison.

Now, what if the Lieutenant Colonel was a Colonel or a General? It would never happen. Colonels don't work on wards. They run things. They are chiefs. And we only have one General, so it's rather unlikely you'll find her working on a ward. Well, if you do, it's because it's war time and all the rest of us are dead and so are all the Captain physicians anyway.

Generals do make inspection tours of hospitals. Now it's hard to imagine a chart thrown by a tantruming physician can get through the wall of physicians and nurses surrounding the General, get past her aide and actually make contact with the General. The physician might just as well kill himself right there on the spot and save everyone a whole lot of trouble.

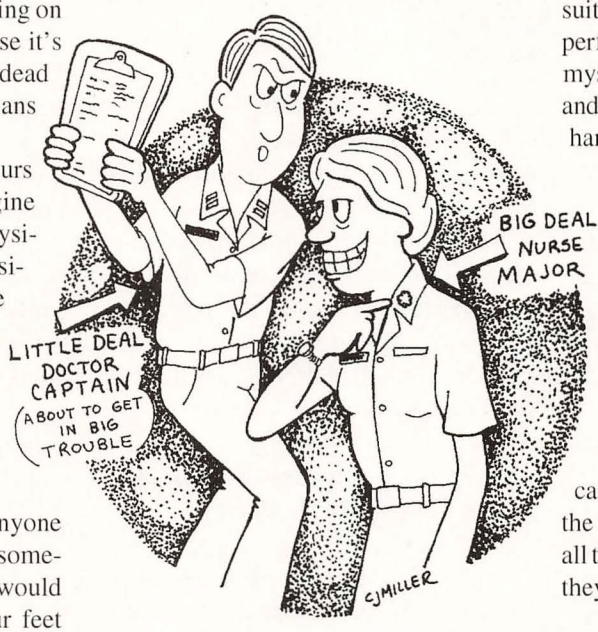
But would a physician, or anyone else on the health care team, throw something or use foul language? How would you treat someone who holds your feet during the sit-up part of the physical fitness test (P.T.), helps you get your forty pound pack on for the road march, gives you mole skin and Band-Aids for your blisters, carries one end of your stretcher, sits next to you when you hear how the budget cut will affect your department, hugs you at your promotion, salutes with you during taps at the funeral of a fellow soldier, lends you an insignia for your official picture, makes sure your uniform looks good and the dry cleaning tags are all off before the commander sees you, gives you shoe polishing workshops, drives you to the airport, picks you up at the airport, teaches you how to say, "hello, I am an American Soldier" in Spanish, French, German, Korean, Arabic, Hebrew and other languages of the world, helps you find a house, holds your hand in a fox hole, sleeps in the next bunk and shares letters from home . . .

No, it would never happen.

Uniforms: Yes, we have them. No, we don't design them. Yes, someone does. We suspect a committee. A large committee.

It is not true that people join the military to wear the uniform and it is not true that they change military branches to wear a different uniform. We only think about it.

I am a winter. I have dark brown hair, brown eyes and fair skin. The worst colors for me are the greens and browns of Autumn. Olive green makes me look like I am in end stage liver failure. Of course



this is the color I have to wear when I wear my Battle Dress Uniform (B.D.U.s) which is the green version of the brown colored desert uniform made famous by General Schwarzkopf during the Gulf War. These are camouflage uniforms that let us blend in with our surroundings. Since I am a Community Health Nurse I don't own whites, which are worn in hospitals, although most nurses wear B.D.U.s.

Sometimes I wear a "class B" dress uniform, consisting of dry clean only pants or skirt and a blouse whose color can be best described as a green not yet invented by Crayola. Over that I wear a black sweater we stole from the British Army, which is sharp. Since black is my color I always try to get stationed in cold climates so that I can look good all year round. I also always try to avoid all wars, so that I always have the option of my black sweater. Dress uniforms are not worn in war zones. I mean, how would you get them to the cleaners?

When nurses from the different branches of the Armed Services get together we always talk about uniforms. You think we get together and talk about delivery of health care, mutual problems of our joint beneficiaries, nursing in the field of battle and stuff like that. Naaah. We compare uniforms.

The Navy talks about how hard it is to keep their whites white, and the burden of looking so sharp all the time.

The Air Force moans about having blue, which everyone looks good in, flight suits that disguise every little human imperfection, and the burden of the Air Force mystique. (Well, we did conquer space and won the Gulf War without getting our hands dirty.)

The Coast Guard doesn't have their own nurses, but their uniforms look like the Air Force. This means they never even explain they don't even work for the Department of Defense and have to be stationed in all those horrible coastal resort towns in Florida, California and Hawaii. Darn . . .

The Marines don't say much because all their health care comes from the Navy and their working uniforms are all the color of dirt, which is probably why they are so tough and yell a lot.

The Army? Well, what can we say? We have really sharp sweaters . . . which we stole? Our dress uniforms are almost as nice as the Canadian Army's dress uniform, which is a gorgeous forest green? No. We just avoid the uniform conversations and say things like, "we have more boats than you. We have more planes than you. We're bigger than you." I really love those multi-services meetings because they're always such a growing, maturing experience.

One thing all of us uniform wearers have in common is that we wear our uniforms well. Why? We like to iron? We don't want someone to correct us in public in front of a small crowd to avoid the public humiliation? We have an enormous amount of self pride? Well perhaps a little each. But also, people died in our uniforms, Verdun, Inchon, Pork Chop Hill, Laos, Viet Nam, The Bulge, Normandy, Kuwait, Iraq, Saudi, Somalia, Haiti . . . You wear it well for them. Even if you don't like the color!

Work can be a very inspiring place. As we all know, sometimes humor is all we have left. A German philosopher once described laughing and crying as a boundary experience. Only humans experience laughing and crying (although some folks swear their pets laugh at them). Herein lies the healing power of laughter.

When the Going Gets Tough, the Tough Laugh

I just finished orientation in a long-term care center, night shift, after working two stressful years at our local hospital on a Medical Surgical unit. I looked forward to the slower pace.

Near the end of my shift, the day shift nurses and aides started to come in. I work with one aide, so some mornings are really busy and the day shift will sometimes help to answer lights. The first nurse in answered a light for us, told me, "Irene fell," and she offered to handle the matter from there.

When I finished my tasks, I went down to Irene's room. The aides had her lying in bed. As I took her wrist to feel for her pulse I said, "She doesn't look too good." Then I announced, "I can't get a pulse."

Everyone in the room started to laugh. They already determined that, bless her soul, Irene had passed on.

I took it for granted she had just fallen to the floor, because Irene was fine just an hour earlier, when we took her to the bathroom. I was so embarrassed! It struck us all as funny to have an experienced nurse be so unobservant. Later, we were comforted to learn the coroner determined she suffered an MI and then fell.

It is difficult to find ease during dreadful and sometimes stressful times, but in health care, sometimes it is all we can do to keep our sanity.

Mrs. Gina Blindt, RN
Fort Madison, IA

When the Going Gets Tough, the Tough Write Poetry

When our hospital made a budget-cutting decision to close the Coronary ICU, a unit which had an excellent reputation, you can imagine how upset everyone was. Can you imagine a guy trying to recover from his MI while watching the post CABG patient in the next cubicle, thinking that's what may happen to him? Or another watching post-drug or alcohol OD's hollering and thrashing about? Intubated sepsis patients, moaning and yelling full-blown ICU psychosis? Infectious nursing home patients in isolation attached to a zillion beeping tubes? Our Coronary unit was meant to be a quiet, peaceful place to recuperate from angioplasty or heart attack. It was not supposed to be a nerve-wracking zoo in which to catch who-knows-what infection from a germy neighbor.

We started to come up with some fun ideas and kept going. We made up an:

Ode to Coronary ICU, R.I.P.

From your MI you will not die
at our Medical Center.
We can't say if you'll catch C diff.
You'll find out once you enter.

From your new stroke you will not croak
in Mr. Doughboy's * haven.
But soon one day M-R-S-A
might snatch that life we're savin'!

That Mr. D., he knows that we
will float to where he shleps us.
But ICU alone can't do,
'cuz MI's don't need sepsis!

Don't know who shut our unit, but
let's ask administration.
We hope they'll see
how VRE prolongs recuperation.

Nowadays insurance pays
for just a teeny bit.
If these MIs are near the guys
with scabies, lice or nits . . .

They'll hafta stay another day
or maybe even more.
Don't CEOs see, if we close
they're worse off than before?

* An alias for our hospital CEO
Name withheld by request

Please keep sharing your work humor with all of us. Liven Up! is a regular feature in the JNJ. Send your story (50 to 200 words) about how you are using humor in your workplace to: Liven Up! Colleen Gullickson, RN, PhD, Rt. 1 Box 167A, Ridgeway, WI 53582. If we use your story you will get 2 copies of the JNJ with your contribution, and an exclusive JNJ T-shirt.

Which New Role Would Best Suit You?

by Janet Rosen, RN, BSN, PHN

1. When another nurse asks you to answer a patient's call light, your initial response is:

A. "What?"

B. "Sure, first just let me just get this lunch tray set up for Mrs. Jones and answer that phone call we've had on hold for ten minutes, then I can get that light. Give me thirty seconds."

C. "Do I have to see him? Let me just use the intercom to ask what he wants."

2. Your attitude towards attending physicians is:

A. What's an attending physician?

B. Just one nuisance out of many to be dealt with in obtaining what the patient needs.

C. Just one nuisance out of many to be dealt with in obtaining a timely discharge.

3. Your patient has been diagnosed with an incurable, progressive disease for which there are several expensive, experimental treatments available. Your response is:

A. "Gee. I'm glad I'm not him."

B. "Boy, he's gonna need a lot of services. Let me get my resource materials out . . ."

C. "Boy, he's gonna need a lot of services, unless . . . Let's see if we can get him outa here and onto hospice fast."

How to interpret the data:

If you picked mostly A answers, we suggest you update your résumé. Consider an immediate leave of absence. It is not at all clear you actually are a nurse.

If you picked mostly B answers, the excitement, advocacy and anonymous glory of discharge planning might suit your temperament. However, before making any concrete job changes, consult with your primary care provider regarding stress management, hypertension risk factors, and diazepam prescriptions.

If you picked mostly C answers, you are ready to leave behind the burdens of bedside care for the rewards of utilization review. You've heard of *spin doctors.* You can excel as a *spin nurse,* using the same set of clinical data to explain (to the doctor) why a patient is well enough to go home and (to the insurance company) why the patient is sick enough to be in the hospital.

If your answers were not consistently A, B or C, you may be an ideal candidate for a career in the changing world of medical case management. Here the ability to be flexible, to go with the flow, and in fact, to have no fixed belief system at all, will only be considered an asset by your profit-oriented employers.

Per Diem

by Julianne Haydel, RN

"Do you think you could pull a shift at the rehab hospital? Evening supervisor?"

I mentally calculated my checking balance. It was just this side of red, so I agreed.

"Oh, thank you," the staffing coordinator gushed, "I'll dance at your wedding."

Uh oh, I thought. This could be very bad. Why would she dance at my wedding just because I agreed to take a shift at a rehab hospital? I've worked as staff in every ICU in town and couldn't see how this could be any worse.

I've since filled out an application for the school for the visually impaired.

I was asked to arrive a half hour early to tour the units and get report from the day supervisors. Immediately I relaxed. The staff was intelligent, friendly and made me feel welcome. A kind soul provided me with a clipboard and a list of evening supervisor duties. There was a typewritten page of phone numbers of resource people I could call. By the time I took the reins thirty minutes later, I had experienced the calm before the storm.

After bidding farewell to the daytime supervisor, I consulted my list of evening supervisor duties. Listed first in big letters was a directive to make sure all the staff arrived. They had. Except one of the nurses, a fifty year old LPN, barely made it through the doors clutching her chest and complaining of chest pain. Her hair was gray, which was not unusual for a woman of her age, but the color was virtually indistinguishable from her skin tone. I set some quick priorities and decided it would look very bad if a nurse died on my shift. They might not make me feel so welcome the next time. Quick as lightning, I arranged for her to be transported to the regional medical center a block down the street, with a promise that if her EKG looks okay, she'll come back and take patients.

At this point, I was the evening supervisor of a hospital where I had never worked and I had seven patients. I looked at the assignment sheet and realized I couldn't give any of them to the already overworked staff in good conscience. I can do this, I told myself. Some vital signs, a little small talk and a whole lot of medicines.

I thoroughly enjoyed the company of one patient. She was pleasantly confused and kept singing the name game song while I tried to convince her that the green trim on her Posey vest really enhanced her eyes. Two of my nurses, like Archie Bunker and Mike, stumbled through the door simultaneously fighting to be the first one at me. My patient enjoyed this tremendously. I felt as though I was in a bad imitation of a Laurel and Hardy movie.

"What can I help you with?" I asked, deliberately trying to moderate my voice to establish some calm in this sea of confusion.

I was unsuccessful. I somehow managed to learn that one nurse had a patient with blue fingers and the other had a patient with a heart rate of 170. Since most of my experience was in CCUs and almost none was in ortho, I was drawn to the rapid heart rate leaving the other nurse to feel rejected. I told the nurse to get a stat 12 lead and page the doctor.

I made my way to the patient's room and found her sitting up and smiling. This was good. The first rule in any ICU, where monitors have a tendency to substitute for brains, is "look at the patient first." The nurse met me in the room with a 12 lead EKG machine. I stood there looking like an idiot until I realized she expected me to perform this task. I was so embarrassed.

There I stood, a CCU nurse who cannot run an EKG. I've ordered six million of them, watched about half of them and read a few more, but I have never actually attached leads and hit the on button. I can do this, I tried to convince myself. I've watched the EKG techs. I faked it.

Paying close attention to the diagram illustrating proper lead placement on the handle of the EKG machine and trying to set my jaw exactly like an EKG tech, I managed to get some semblance of an EKG. Afib with rapid ventricular response.

No PRN orders. We'll watch the patient and wait for

the doctor to call. I left the nurse to watch the patient and headed to the room where Mr. Blue Fingers was waiting for me.

I was forced to look to my repertoire of cardiac experience for guidance on Mr. Blue Fingers. A brand new cast put on at eleven this morning seemed to be a tad too tight. There was no capillary refill. In heart patients we take circulation problems very seriously. Call the doctor, I advised the LPN in charge of this patient. He already had, thank goodness.

I returned to the nurse's station to chart my experiences and wait for the doctors to call. The phone was ominously silent. I checked and medicated my third patient who needed an "ICP." I'm glad I asked a nurse how one went about getting an Intracranial Pressure on an ambulatory patient before I did it myself. Seems ICP in a rehab hospital stands for Intermittent Cath. I can only guess what "P" stands for. Finally, the phone rings.

"This is Dr. Smith."

"Yes sir, your patient seems to have some circulation problems where the new cast was put on this morning. His fingers are turning blue and he complains of slight pain."

"Why are you telling me this? I'm a cardiologist."

"Oh, in that case, your patient is in afib with a heart rate of 170." I have really established my credibility with this doctor.

He leaves me some orders for verapamil and dig. In the back of my mind I think it would be much quicker to simply cardiovert her and who would know? My conscience won out and I dragged the crash cart into her room so I could monitor her heart rate.

Finally, I am done. I enjoyed talking to this charming patient and educating her about afib. A little gift from God perhaps, a reminder of what nursing was all about. Still no word from the orthopod.

I checked Mr. Blue Fingers again and found that his pain had increased considerably. I asked his nurse to please page the physician again. He already had, twice. When was the first call made to the physician? I learn that the day shift had called him three hours ago. Do we have a saw?

Now, I am not very good with power tools. I was seriously wishing for another afib patient as the nurse returned with a circular saw. He tried to reassure me that the saw was designed specifically to avoid injuries to flesh. I don't think my patient was reassured when he saw my trembling hands wielding a power tool destined for his arm. Miraculously I managed to cut the cast off him right as I was paged to go answer the phone.

"You did what?" the orthopod screamed.

I quietly repeated myself.

"You didn't have to do that. You should have just trimmed the edges around his fingers."

"You didn't have to wait three hours before returning your page, either," I reminded him.

Finally things seemed to quiet down a little. My own patients were eating dinner in the dining room and Mr. Blue Fingers was quite content now that a rich supply of oxygen had been restored to his hand. Miss Afib had converted and was looking forward to her next dose of dig. Somewhere down the hall I could hear someone singing, "Julianna Anna bofanna . . ." It rather grew on me. I was humming it to myself when Mr. Blue Finger's nurse asked me to come and look at another one of his patients. I looked at my report sheet and noted that this patient was a ninety-two year old DNR in the back corner.

His breathing was fast and labored. His heart rate was up, his pressure was down and his chest sounded like a washing machine. His O_2 was at 100 percent per face mask and he had low dose dopamine going for renal perfusion. I held his hand for a minute and asked for his chart. Surely there must be something we could do for this patient.

I asked the nurse to call for his family. While he was gone I thumbed through the chart looking for a furosemide order or some morphine or anything that might make this gentleman a little more comfortable. I glanced at the progress notes and then it dawned on me. I did not see a DNR order. I quickly checked a pressure: 60/Doppler. I screamed for the nurse to page the doctor STAT and ask for the crash cart. I really don't want to do this, I thought. Surely, there was just a mistake. I desperately re-read in

Listening for Vowel Sounds

vain the order sheets looking for a DNR order scribbled in the margins or a note in the progress reports indicating a DNR had been decided upon by the family and its omission from the order sheets was just a careless error. Nothing.

"Page respiratory and set up a vent. Make sure the suction is operable. Get some restraints and some sedation in case we have to intubate." I usually try not to bark orders but my mind was on what we were about to do to this ninety-two year old gentleman if I couldn't get a DNR order right away. At this point, I would have settled for a family member to show up and ask me not to code this patient. No such luck.

The phone rang. It was the same cardiologist I established my credibility with earlier in the evening.

"Are you sure?" he asked, after I gave him report. Who can blame him for thinking I'm a dingbat?

"Sir, there's no DNR order and I'm going to have to code your patient if I don't get one now," I said.

"Well, you have one." He cooperated. Thank Goodness. I offer up a silent prayer of thanks.

Before I let him off the phone I made a desperate attempt to get him to repeat the order while another nurse was listening for protocol's sake. Not one of us could figure out how to listen on the extension so my nurse and I settled for taking the DNR order cheek to cheek separated only by the telephone as the doctor repeated himself. Larry, Moe and Curly do the No Code thing.

On the way back to the patient's room, we were met by the patient's daughter. She knew about the DNR order and the nurse brought her some water and tissues and encouraged her to hold her father's hand as he died.

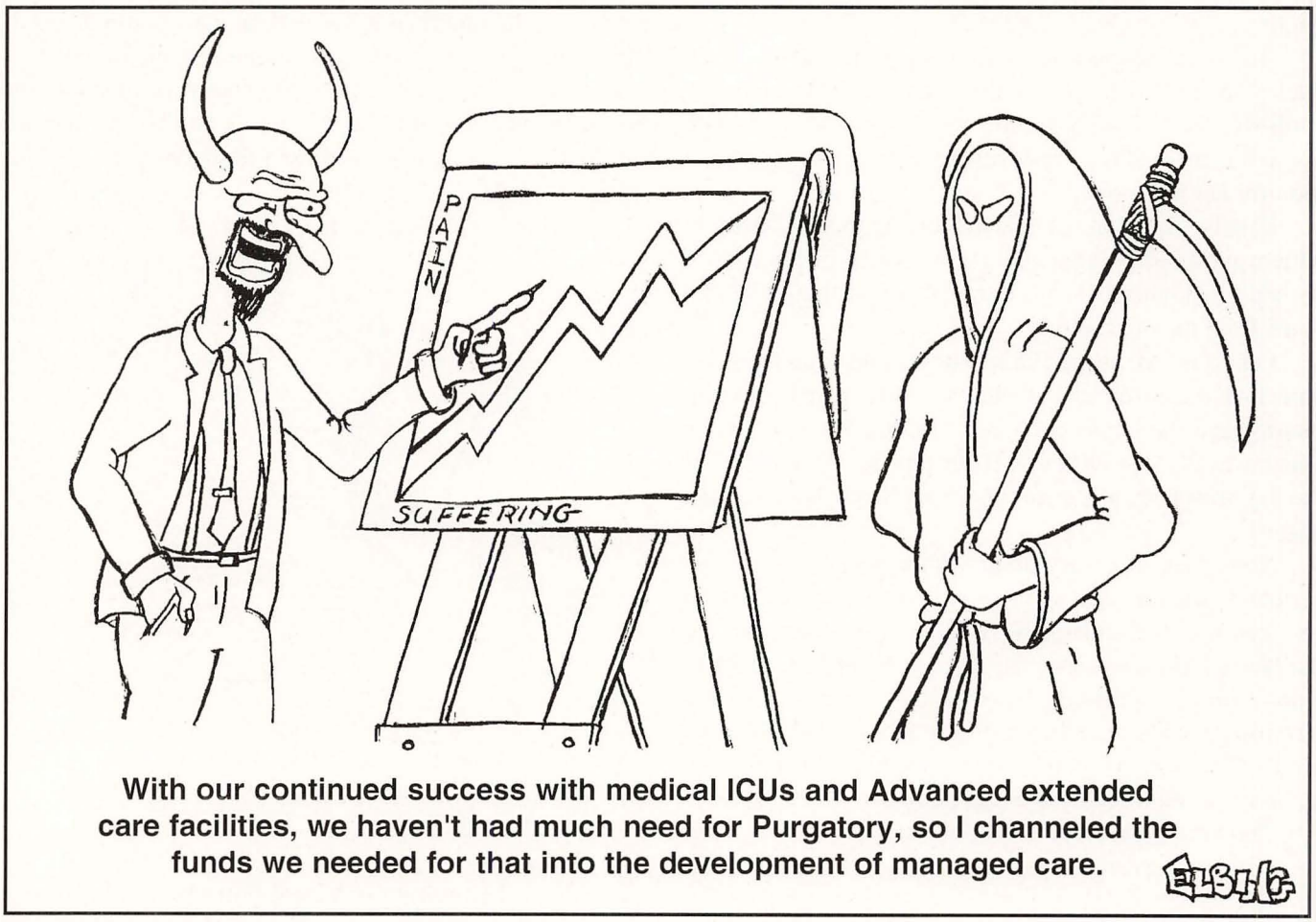
We did one thing right, I thought.

After that shift, back in my own bed, I wondered why I did this to myself. Why did that nurse with chest pain do it? Why didn't I just go get a job where I knew what to expect? Sure, the money from per diem work was better, but it was unreliable. It's true I hated the alarm clock and I needed time with my son, even if it meant less job security and a lower annual income. That's what I tell people who ask. In these quiet moments, I wonder if I do it to shave off hours of purgatory time.

The phone rang. Who would be calling in the middle of the night?

"Can you take a shift in the morning? Rehab hospital supervisor?"

"No," I said, leaving no room for discussion. I was acutely reminded why I continue to do this to myself.



With our continued success with medical ICUs and Advanced extended care facilities, we haven't had much need for Purgatory, so I channeled the funds we needed for that into the development of managed care.

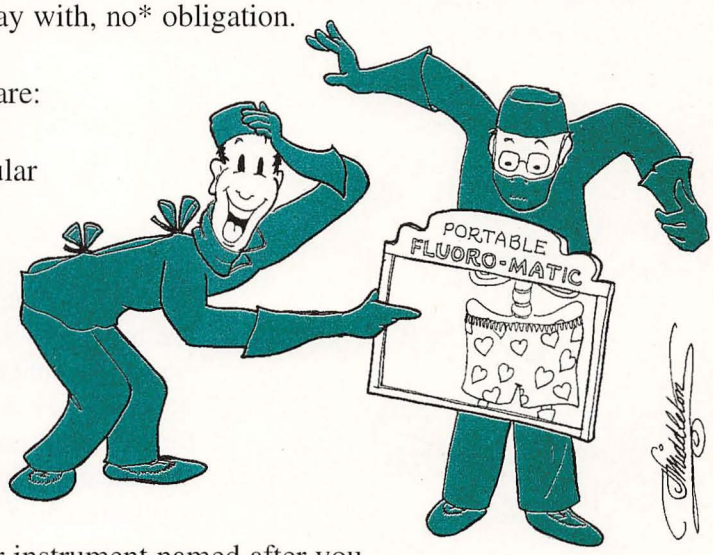
Attention All Orthopedic Surgeons

You have just been pre-approved for this special limited time offer.

Be the first orthopod in your hospital to join The Toy of the Month Club. This special offer is FREE. Yes, FREE! Just fill out the attached registration card, or have your nurse do it for you. Write in your special ID number and have your hospital mail it in. Then sit back and every month receive your new toy. You will receive either a new instrument or prosthesis to play with, no* obligation.

Some of the special products we have in store for you are:

- A new nail that fixes humerus, tibia, femur, acetabular and metacarpal fractures with a few minor adjustments. Complete in three simple-to-use pins.
- A set of adjustable screwdrivers with interchangeable heads in both metric and U.S. standard.
- A new hand-held fluoroscopy unit** guaranteed to radiate through anything.



As a special sign-up bonus, you will get one implant or instrument named after you.

If you are one of the first fifty to respond to this offer, you will receive three free happy hours given to the OR staff in your name.

If you sponsor four other orthopedic surgeons to join The Toy of the Month Club, you get your very own sales rep, complete with lunches and tickets to sporting events. Imagine! Your own sales rep to harass and blame, in addition to your nursing staff!

So act today, Don't be the only one at your next meeting (free trip) without the newest toy.

Toy of the Month Club

call 555-TOY-CLUB
ask for Michael Roth

* consignment fees, shipping, handling, travel, destination, stocking and origination fees will be charged to your hospital's OR budget.
** FDA approval doubtful.

Student Nurse Cut-Ups!

That's a Rocket

My classmate and I were doing our clinical rotation in the operating room. During surgery, Dr. Smith complained to the circulating nurse that the keys in his pocket got caught between the table and his thigh. He asked Miss Jones to slip her hand between his scrubs and cover gown and remove the keys. Miss Jones complied and the surgeon's face soon turned bright red. He jumped back from the table and cried, "Miss Jones! Miss Jones! That's not my pocket!"

Marcia McCormack, BSN, RN

Medical Terminology

After attending a lecture on hygiene and practicing these skills in our nursing lab, the students apply this knowledge in a long term care setting. When asked about their experiences, one student reported that he learned a new meaning for the word diaphoresis: A condition student nurses develop while bathing and dressing a 91 year old, unstable client in a three foot by four foot bathroom with an ambient temperature of 80 degrees.

Susan Ames, RN, MS

Did You Report That?

While describing how to divide the abdomen into quadrants in physical assessment lab, one student said, "The midline is from the bottom of the sternum to the syphilis pubis."

Ruth A. Shearer, RN, MSN

Universal Precautions, Please!

The first hour of my first day on my care of the elderly clinical, I had to give a bed bound patient her medication. The medication was in syrup form. Despite my best efforts to get her to swallow the medicine, a little of it dripped down the side of her mouth. I reached over to get a tissue, but unfortunately she beat me to the mopping up process. She had reached down into the bed, removed the extremely soiled pad from between her legs, and wiped off her face.

Heather Steers

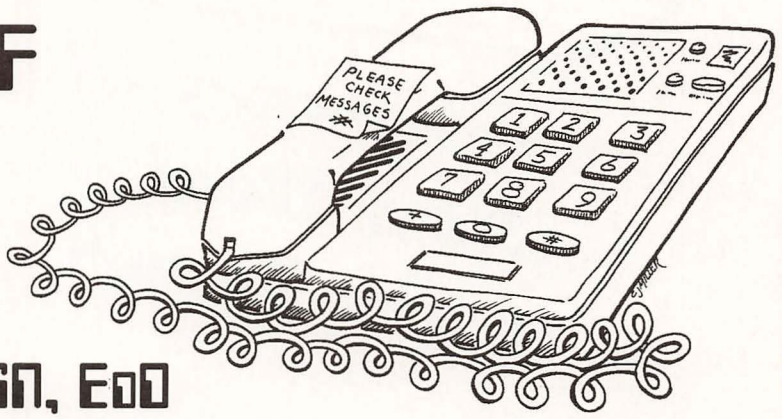
Time for ASA PRN

Our hospital uses syringes that have the safety shield that slides up over the needle. I was preparing to give my first injection, and positioned the patient on his side facing away from me. As I slid the shield down I inadvertently pushed the plunger up, sending the medication flying. To my horror, I watched the patient wipe off his face. He turned to me and said, "Nurse, can you get me some Tylenol? I think I'm getting a fever. Sweat just popped out all over my forehead."

Tara Johnson

Student Nurse Cut-Ups is a regular feature in the Journal of Nursing Jocularity. Send your funniest true student nurse stories (50 to 150 words) to us at JNJ Student Nurse Cut-Ups! Judith Vallery, EdD, RN, 15106 Morning Tree, San Antonio, TX 78232. If we use your story you will get 2 copies of the JNJ with your story, and an exclusive JNJ T-shirt.

A Nursing Student's Guide to Optimal Use of Voice Mail



BY RUTH A. PEASE, RN, MSN, EdD

It is not easy to be a nursing student. So much to do, so little time. Technology can help, though. Here's how one nursing student used her voice mail to help control her time and her life.

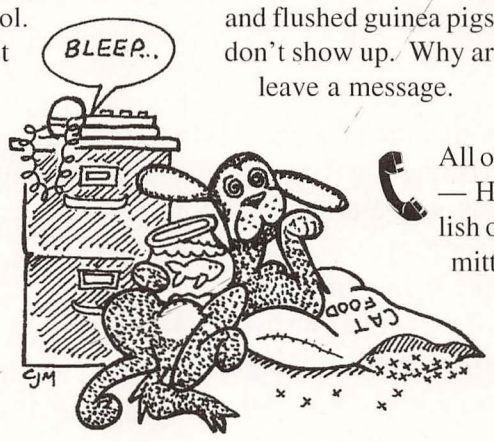
Hello. This is the voice mail system for Glenora. I'm back in school working on my BSN. I'm sorry but I won't have time to return your call for several years. If you'd like to leave a message, please choose from the following options. You may exit this message system at anytime and take a psychotic break by pressing the star button on your touch-tone phone.

If this is the cleaning service, please press #1 now. (Bleep) —Hi there service! I tripped over a large dust ball last week so it is time for my semi-annual cleaning. Come quickly. Situation hazardous. The check and key are hidden you-know-where. Watch out for the dog. We've been feeding him cat food lately because we ran out of dog food and he is acting weird. Leave a message. Thanks!

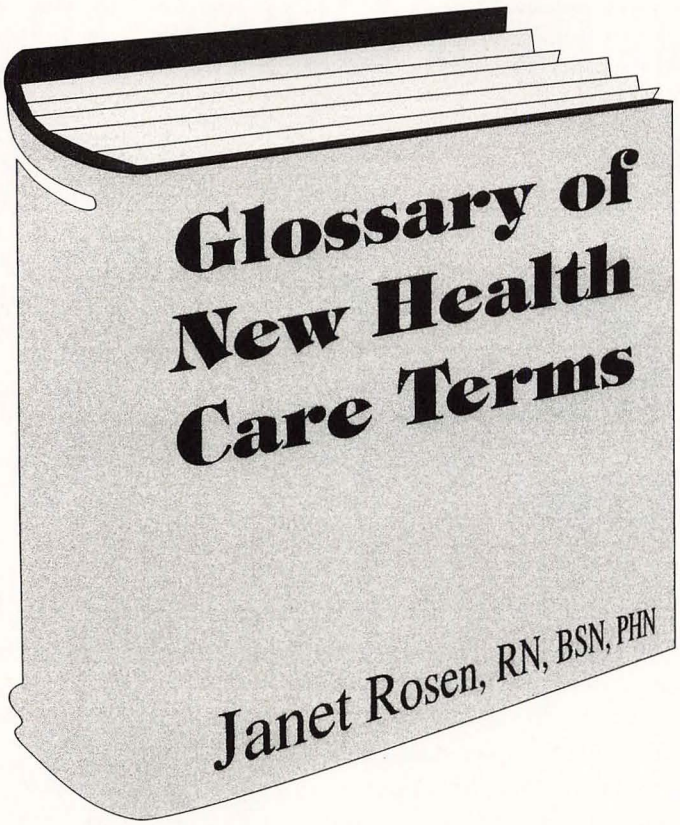
If this is Mother, please press #2 now. (Bleep) — Hi Mom! I'm doing well in school. Thanks for the loan. Could you just subtract it from my inheritance? I also received the twenty pre-packaged frozen home-cooked meals. Your grandson Josh just loves that meatloaf. No, I won't need to borrow your 1939 typewriter, but thanks! Leave me a message! Love ya!

If this is Josh, please press #3 now. (Bleep) — Hi Josh! How is your growth and development coming? Fine, I hear. I kiss you every night as you are sleeping, when I get home from class at midnight. I got your note about the dog food. Your clean laundry from the last two weeks is still in the dryer. Grandma sent more meat loaf dinners. Really, if you put a little more catsup on, you might like them. Yes, my first grade was a B. You must show me how to use that spell-check again. Check your e-mail when you get home from school. You forgot yesterday. Love ya!

If this is the plumber, press #4. (Bleep) — Hi Mr. Hassenphlug! I waited for you from 8 am to 4 pm, then had to go to work. Where were you? We're using bottled water and brought over Uncle George's old outhouse. I am also using the outhouse as a private study. It has no lighting, but my laptop computer is back-lit. You have been my faithful plumber through flushed diapers and flushed guinea pigs and two divorces and now you don't show up. Why are you doing this to me? Please leave a message.



All other callers, press #5. (Bleep) — Hi there! I promise to re-establish our relationship/rejoin the committee/contribute/pay you when I graduate. Think of me at holidays. You are welcome to leave a message. I'll return your call next June.



New terms are flung out every day. It's often hard to tell from the context if they're euphemisms or smoke clouds. Tired of falling behind in managed care neologisms? Well, here's what they mean when they say . . .

Case management is a professional discipline encompassing an integrated, multidisciplinary view of the clients' real and potential short and long term needs and resources, where you get to make suggestions no one is happy with, while you are trying not to become a basket case.

Cross training is the first professional educational system that actually describes the effect it has on its participants.

Full risk contracting means that the insurance company (or HMO) pays the contracting hospital and doctors a flat rate per insured person to take care of everything. The insurance company gets to keep the rest of everybody's premiums. Nurses need to know that the insurance company CEO is taking an overseas vacation, the hospital CEO is preparing to use a golden parachute, the hospital is completely screwed, and you had better start studying for the real estate license exam or take the post office test. (The flat rate per person is called **capitation,** but what that really means is that if your doctor makes too many specialist referrals they will cut off his head.)

Discharge planning is a professional discipline engaged in successfully only by those odd enough to posess the emotional profile of a clinical social worker and the autonomic nervous system of a Wall Street trader. It requires the ability to calmly conduct a telephone needs assessment with an overwrought, hard of hearing family member for whom English is not a primary language, while standing at a nursing station during morning rounds with a resident sticking a chart under your nose demanding "stat discharge planning" on a newly admitted patient and a nurse is asking you why you didn't get Mrs. Jones the taxi voucher she didn't get around to asking for yet.

PPP (Preferred Provider Plan) means your doctor isn't part of it. It doesn't matter if she was on it two months ago, when you signed up. She will have dropped out by the time you require services. (Sometimes known as PPO, which means they get Pretty Pissed Off, if you use an outside provider.)

Stable patient is the epitome of a paradox. In acute care hospitals, it is simultaneously a fictitious entity, since the moment a patient nears this condition she is transferred to SNF, and a ubiquitous entity, since only a patient in this condition can be assigned to an unlicensed caregiver (whose numbers are increasing daily).

Utilization review is a professional discipline that applies rigorous standards in allocating health care resources appropriately. It requires the ability to sit, open chart before you, pen poised, ready to speak, ignoring questions from house staff about why you haven't talked to the attending about when Mrs. Jones can go home, for twenty minutes at a time while your call to an insurance company is on hold. If you hang up or, worse, use a patronizing tone when spelling out "infarction" for the third time to the clerk who flunked basic medical terminology, your employer's claim will be denied.

Upright Posture in Syncopal-Induced Facial Injuries: Correlations with the Inebriation Scale

by Sarah J. Perry, RN, CCRN, MA

Rapid rising from a recumbent to an upright position has been implicated in syncopal-induced facial injuries among a population of fraternity members in a geographically diverse collection of college campuses. Volunteers from a fraternity on five college campuses in the Midwest took part in a study to demonstrate the truth of this hypothesis.

The volunteers were all physically healthy males between the ages of 18 and 27 years, attending college full-time. The volunteers had been enrolled as full-time students for periods of time ranging from one (1) semester to seventeen (17) semesters. Aside from "a liver that hangs to the knee" in several of the older students, all subjects were found to be prime specimens as defined by insurance company actuarial tables and various other vague measurements of manhood.

Overall, the rapid rising test was positive in 96% of the subjects in the 18 to 20 age group following syncopal-induced recumbent positions associated with severe inebriation. Testing was positive in 74.3% of subjects in the 21 to 24 age group. Only 11% of subjects in the 25 to 27 age group were induced to rise to an upright position; of these, half had a positive test. The standing test, in conjunction with judicious application of the Inebriation Scale, can serve as an alternative to blood alcohol testing in this population when blood alcohol testing is just too much trouble.

Methods

Subjects: One hundred fifty (150) male volunteer subjects with a mean age of 23 accepted the challenge as a means of earning extra credit and getting excused from Monday classes. All volunteers reported for testing before a traditional weekend keg party, at noon on Thursday. A control group of one hundred (100) volunteer subjects (85 men and 15 women), whose mean age was 30, was recruited at the local plasma donor center in each of the college communities.

Before acceptance into the test group, each volunteer underwent a physical exam and health history questioning consisting of detailed questions such as "Hey, howya doing?" and "Are you crazy or something?" All subjects responded to these questions in an appropriate fashion.

Informed consent was obtained from all volunteers. This consent was documented and consisted of signed, dated, official okey dokeys, or in a few cases, witnessed verbal responses of "yeah, sure" by the volunteer. The study methods were approved by the fraternity's Code of Ethics.

Measurement and Data Collection

The Inebriation Scale has been developed over a period of years during fraternity rush. This five point Likert scale was previously used as a measurement of a candidate's suitability for fraternity membership (See Table 1).

While a fraternity pledge might strive for the "shitfaced" category, those who move to "shoe puking drunk" are only likely to be accepted as brothers if the shoes on which they puke are their own. While it is true that some cannot accurately discriminate between the discrete points on this scale (after a few beers, many are seriously challenged by numerical data), there is adequate documentation of the finer points of the scale in chapter bylaws that we feel confident in using it for this study.

The control group, rather than being tested prior to a weekend, worked on a come-as-you-are basis since these volun-

Table 1. Inebriation Scale

1	2	3	4	5
No thank you, I promised my mom I would not drink	More wine for me and my merry men, bartender	Shitfaced	Commode Hugging Drunk	Shoe Puking Drunk

teers were not constrained by the same tight class schedule as the students.

Data Analysis

The criterion for a positive test was defined as the failure to meet the challenge of verticality when roused suddenly from a syncopal state and urged forcefully to an upright position. Endpoints of the test were defined as:

- immediate return to the horizontal position, with or without injury to facial structures
- rapid collision of face or other body parts with immovable objects, with or without hemorrhage
- defilement of the researcher's attire after subject has progressed to stage 5 on the inebriation scale
- flaccidity and inability to be roused to an upright position
- passage of more than three days without regaining consciousness
- any indication that the subject has remained at stage 1 while pretending to have achieved stage 3 (shitfaced delusional state)

Results

Four subjects were disqualified from participation, three for failing the verticality challenge before beginning the study, and one control subject who did not talk nice to the researchers.

Three members of the control group failed the verticality challenge after also failing to mention that this was a frequent condition in their lives. These members were not disqualified since it could not be shown that the researchers had ever sought this information.

The following results were tabulated at the end of the study:

At stage one, four volunteers had delusions of stage 3. The endpoint in their studies was reached when they tested as completely sober and a discredit to the fraternity. None of these pledges was subsequently found acceptable for membership.

At stage two, seventeen members of the control group were unable or unwilling to meet the verticality challenge. Of these, fifteen attributed their failure to a particular attitude toward the research project. As one subject aptly stated, "Buzz off, eh!"

One hundred and forty-six volunteers reached stage two. Only fourteen leveled off at this stage, while 132 progressed to higher levels. Of the fourteen who remained in stage two, all exhibited a general affability and bonhomie, maintaining the "hale fellow well met" attitude even after sustaining minor facial contusions from failure in either the verticality challenge, or following collisions with each other or upright immovable structures.

Of the 132 volunteers who progressed beyond stage two, a large number were noted to have sustained disruption of their facial structures to a greater or lesser degree. One subject, on wagering that he could do a back flip from the balcony and land on his feet in the parking lot below sustained rather severe facial injuries when the payoff was increased for "best two out of three."

Flaccidity was a problem encountered in both the control group and the test group. In the test group flaccidity was nearly always associated with achievement of stage five, and often preceded an extended period of unconsciousness. In the control group flaccidity was about equally divided among those who had a previously unidentified "love of the grape" and those who merely remained flaccid as a matter of attitude toward scientific inquiry.

Defilement of the researcher's attire by the subjects was about equally common in the control and test subjects.

P values were all in the range of one liter or more, though it should be noted that bladder capacity was greater in the test than in the control group.

Discussion

This study attempted to describe an alternative method to the costly practice of blood alcohol testing conducted on fraternity pledges taken to hospitals for treatment of major and minor injuries sustained during college social events. The results show to our satisfaction that a judicious application of injury assessment used in conjunction with the Inebriation Scale can yield results that are close enough for government work. The advantage of this method of testing can be seen in the savings of student dollars, which can later be pooled to purchase another keg.

One failing of the study was a lack of hedging by the researchers. Such hedging presented earlier in the report would have made it much simpler to segue into the implications for further research that should appear here, but what the heck, we still will find other things that this study should compel us to research. We need to look at the result of the facial injuries sustained by fraternity members in terms of how the injuries inhibit or promote their success in the business and professional fields, as well as the effect on their social standing.

An even more interesting study might delve into the connection between the repetitive and cumulative effects of these injuries on the ability of fraternity members to complete college. Further, one might even look at the number of fraternity members or dropouts who help to comprise the control group. Correlation of this information with the attitudes found in the control group could produce study material sufficient to last a lifetime.

Postscript: This subject's injuries did heal and aside from the loss of a small amount of little-used frontal lobe tissue, he has sustained no permanent effects as a result of losing his wager. He was found to be an acceptable candidate for membership in the fraternity.

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Pacemaker, Pacemaker
(to the tune of "Matchmaker, Matchmaker")
by Kay Scharn, RN, MSN

Pacemaker, pacemaker give me a beat.
Send out some blood, down to my feet.
Pacemaker, pacemaker, my brain won't wait,
so give me the perfect rate.

Pacemaker, pacemaker I have a block.
My EKG shows Wenckebach.
Send me a jolt for I'm longing to be
alive for my morning tea!

My sinus node's on vacation,
my AV node doesn't care.
My output is somewhat less than I need
to keep breathing and growing hair!

Pacemaker, pacemaker give me a beat.
Send out some blood, down to my feet.
Pause after pause I am turning quite blue,
so give me a beat or two.

Pacemaker, pacemaker I need a rate.
Sixty is fine, eighty is great.
Pacemaker, pacemaker why can't you see,
I'm getting quite SOB!

Pacemaker, pacemaker my lips are blue.
Please send some beats, I need a few.
Without some blood going up to my head,
they soon will pronounce me dead.
I need a quick intervention.

I'm getting worse, have you heard?
They say my block is progressing.
I've moved out of second and into third!

Pacemaker, pacemaker please don't be mean.
You know that I hate atropine.
Pacemaker, pacemaker no time to rest.
If you don't work, I arrest.

Those Tubes Are All Over My Patients
(to the tune of "My Bonnie Lies Over the Ocean")
by Nancy Leone, RN

My patient has tubes and attachments
They're inside and on his body.
My patient he just loves to pull them
And cause some great pain you can see.

ET, JP are somewhere in there, I know, I know.
SCD, EKG. What else is there to show?

My Foley lies over the left leg.
My IV is in the right arm.
My NG is in the left nostril.
Oh, where can I put this? Oh, where?

Posey, Posey, it's the next thing to go, to go.
Chest tube, J-tube. Too many tubes to show.

Humor as a Butterfly?

By William F. Fry, Jr., MD

Part Two of a Three Part Series

The assortment of common beliefs about humor and laughter goes a long way towards running me up the tree. I described one of these misconceptions in a previous article [1997. Misconceptions of Humor. *Journal of Nursing Jocularity,* 7(2), 38-40]. I stated it is a misconception that humor is a trivial and unimportant part of human life. Nothing is farther from the truth—and I will be happy to discuss the issue with anyone who doubts this. But read my article before we debate.

A second major source of my dismay is an idea, put forth so many times, by so many people who should know better. It's the idea that humor is a fragile, ephemeral, insubstantial, gossamer part of the human experience. This is the "here today, gone tomorrow" fallacy.

A well-publicized version of this fallacy is by humorist and poet E. B. White. He said humor is like a butterfly, in that if you try to dissect a butterfly, you will kill it. White's warning may apply to butterflies; I have no justification for questioning his wisdom about butterflies. But I am of the firm opinion that humor is more appropriately compared with a phoenix than with a butterfly. Humor is forever arising and re-arising out of all sorts of difficult situations and dilemmas. That is one of the strong points of humor. It can take hold of a difficult situation and, in most instances, resolve or at least calm the difficulty.

Indeed, humor and mirthful laughter are instruments for conflict resolution.

Humor and laughter are keys for removing obstacles to constructive interactions and resolving impasses in negotiation. Dramatic examples of this power frequently occur during diplomatic or political interaction. Also, persons unfortunately held hostage or imprisoned have identified humor as a major force in maintaining psychological balance in their unusually stressful circumstances. They speak of humor as an aid in dealing with their stress, or as helpful in sustaining rapport with the oppressors. This demonstrates the forceful substance of humor.

Persons unfortunately held hostage or imprisoned have identified humor as a major force in maintaining psychological balance in their unusually stressful circumstances.

Humor comes forth and eases tensions in other difficult times, too. Nursing care is a big one. It is proverbial for nurses and other health care providers to gather periodically for laugh catharsis. Sometimes the jokes are about the doctors, sometimes about patients, relatives or visitors, sometimes about each other, frequently about administrators and utilization managers.

Humor also serves powerfully to establish and maintain positive rapport in the provider-patient interrelationship. Humor varies in type and content in different health care contexts. And humor variation will be influenced by who is participating. However, you cannot deny the strength of humor.

Of all the pleasureful experiences enjoyed by humans, humor is one of the most speedy, swift in arising, swift in effect and swift in passing. Unlike sexual intercourse, humor requires little foreplay—maybe just a fun-asserting gesture, or a faint modification of voice tone, a wink, or "did you hear the joke about . . .?" Even with intense laughter, the duration and energy involved are significantly less than with sex. Consequences are not so potentially durable as with sex. Humor can occur spontaneously, almost anywhere. Psychologist Bob Provine does much of his research observing humor and laughter in the malls. Can you imagine having sex in the mall?

The swiftness of humor and mirth can actually be recorded by physiologic monitoring of mirthful laughter. Heart rate increases with mirthful laughter almost instantaneously, and can drop off almost as quickly as the laughter ceases. This speed is seen with other humor physiology.

The characteristic swiftness of humor can be deceptive and may suggest a sort of ephemeralism, a lack of substance, a transitoriness, an impermanence. This impression could lead towards seeing humor as fragile and delicate. In view of the enormous range of humor in the human experience and its range of universal distribution, it is rather amusing (and silly)

to be concerned about humor being fragile. In contrast to the speed of contemporary moments of humor, its history with the human race is anything but short and ephemeral. Research has indicated humor to be an inherited human trait, part of the human genetic template. We are all born with the potential of developing a sense of humor. Other research suggests that humor-related behaviors first appeared in common ancestors of the Great Apes—gorillas, chimpanzees, orangutans and humans—probably beginning some six million years ago.

There are occasions when other emotions oppose humor and supersede mirth–emotions like fear, anger and depression. Other less forcefully opposing emotions can be embarrassment, humiliation, chagrin, anxiety, mourning and loneliness. If humor is introduced at the right time, in many instances the major negative emotions can be inhibited or aborted. This powerful capacity of humor has a wide range of significant health values, which are based on diminishing the well-documented noxious effects of the negative emotions. The American artist James Whistler created a personal logo that depicted a butterfly but with a tail having a stinger at the end. His logo was intended to represent his esthetic capacity (the butterfly) which was high-powered (the stinger). The stinger also represented this special personal brand of humor—satire, wit and sarcasm. Humor is not limited to one or two modes. Scholar Arthur Berger designates forty-five different types of humor in general, frequent use.

Besides being wrong, there is a disadvantage for persons to believe that humor may be fragile. Detrimental possibilities. A detriment lies in the impression that humor should be left to the humorist, a professional expert, with the implication that ordinary citizens don't possess the fine skills to create and use humor without destroying it, that citizen clumsiness combined with humor fragility constitutes too great a hazard. Were this attitude to become dominant, we would have situations where scores of people would not participate in humor, afraid that their participation would be damaging. "Humor is precious, but fragile, and I could destroy it." We could develop traditions that would restrict humor to those experiences in which safety would be guaranteed in some presently unimaginable fashion. (I don't even want to think about how this would work.) A humor dictatorship could develop. Spontaneous humor would either be out the chimney or go completely underground—as long as the "fragile" idiocy persisted.

Another consideration is that this misconception of fragile humor is a form of bigotry, as are many of the other misconceptions about humor. Instead of directing prejudice at people, these misconceptions are bigotry directed at behavior. Many of the same principles that we have learned about people-prejudice apply to prejudices held about humor. Most people grew in perspective during the recent mid-century and have come to recognize that bigotry is a foolish, twisted, crippling handicap. The roots of bigotry grow from the soil of ignorance (insufficient knowledge) and fearfulness (a sense of vulnerability). Origin of the prejudicial nature of humor misconceptions is similar.

Research has indicated humor to be an inherited human trait, part of the human genetic template.

As in the case of the misconception that humor is trivial and unimportant, the major impetus for believing humor is fragile comes from lack of knowledge about the truth about humor, and from fear or uneasiness about its evident power. In other words, not only is the idea about "fragile" humor mistaken, it isn't paying attention to the real concern, about power of humor, with humor. It's an error, and it's a fraud. It covers up the actual underlying belief. The fear of humor is based on the underlying belief taht humor is so powerful that it is highly dangerous. Not fragile, but rather so powerful as to be a danger.

A special factor is operating in the case of this "fragility" misconception. Whereas fear of humor in the "trivial" misconception (previously discussed) seems to be based on perception of the power of humor, the fear regarding humor power in the case of "fragility" might be more focused. Often a prejudice reveals something of the fear that underlies the prejudice, offers a clue or hint of what lies underneath the facade. That seems to be a possibility here. "Fragile" humor might mean "fragile" human, the fragility of what happens to a person who is laughing. Not only does the person who makes you mirthful meddle with your emotions, but also he or she plays with your bodily processes. When you joke and kid around, you make others' hearts beat faster, increase their circulation, change their breathing pattern, change the hormone and immune elements of their bloodstreams and make certain muscles to be active and others relaxed, so they feel physically weakened. That's a very high level intimacy; a very intensely personal interaction takes place.

Of course, this is an important source of bonding. This valuable, positive effect was probably one of the survival mechanisms that has kept humor with us through all these centuries of adaptation. But there are times when people don't want to get that intimate. They are edgy, uneasy or they've got something else in mind. But, the power of humor is compelling, difficult to resist. This effect could create a sense of personal fragility. You see what I'm getting at.

Identify prejudices for what they are and recognize their true origins. But if you want to deal realistically with a prejudice, or misconception in yourself, another step is necessary. You need to confront it and take actions that oppose those which would be appropriate to the prejudice. In the case of people-prejudices, this means establishing relationships with those you would tend to avoid, and letting nature take its course. In the case of humor-prejudice, or the misconception about the fragility of humor, it means discarding those faint-hearted ways of dealing with humor or using humor that have made you so tentative and hesitant about humor—afraid of ruining a joke, destroying the humor in life, making people uptight and angry that you might spoil their fun.

Be bold with humor. It's been around for a long time. It's not likely to pass out or fade away.


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CULTURE AND SENSITIVITY
HE'S COMING!!!
QUICK, UNDER HERE BEFORE HE SEES YOU.
YOU DON'T WANNA GET CORNERED BY HIM ON AM ROUNDS!
NO TELLING WHAT WILL SET HIM OFF BUT JUST ABOUT ANYTHING AND EVERYTHING DOES!
HE FLEW INTO A RAGE WHEN HE SAW A FLY IN THE UNIT AND JUST RIPPED INTO SALLY ABOUT IT AND SHE'S NOT EVEN A NURSE... SHE'S PASTORAL CARE!
BILL CAUGHT HELL FOR NOT PAGING HIM "STAT" WHEN HIS PATIENT HAD A BM AND KAREN GOT HOLLERED AT FOR BEEPING HIM DURING SURGERY
GOD FORBID YOU HAVE TO TELL HIM HIS PATIENT IS HYPOTENSIVE, BLEEDING OR JUST NOT DOING WELL. YOU'RE DAMNED IF YOU DO AND DAMNED IF YOU DON'T!
PERSONALLY I THINK HE'S A STITCH SHORT OF A SUTURE LINE BUT WHAT ARE YOU GONNA DO?! HE'S A SURGEON AND BRINGS IN THE BIG BUCKS!!!
I KNOW EXACTLY WHAT YOU'RE SAYING... I'M MARRIED TO HIM!


THE ADVENTURES OF
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THE P.M. SUPERVISOR
By C.J. MILLER
HOW WAS YOUR WEEKEND HUMOR CONFERENCE ON THE CRUISE SHIP TO THE BAHAMAS?
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IT WAS THE MOST FUN I HAVE EVER HAD EARNING CEU's. I BROUGHT PICTURES...
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FUN
SHOPPING
SHOWS
MIDNIGHT BUFFET
MUSTER STATION B
FIRST ACTIVITY, REPORTING TO MY MUSTER STATION.
CATCHING RAYS AND ENJOYING THE PAMPERED LIFE.
HUMOR Rx
HA-HA-HA
HA-HA-HA
HA-HA-HA
THE JNJ HUMOR CONFERENCE WAS WONDERFUL WITH INTERESTING SPEAKERS AND PROGRAMS.
WONDERFUL FOOD, ESPECIALLY THE CAPTAIN'S DINNER.
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YOU HAVE GOT TO EXPERIENCE IT!

IV Team Wordfind

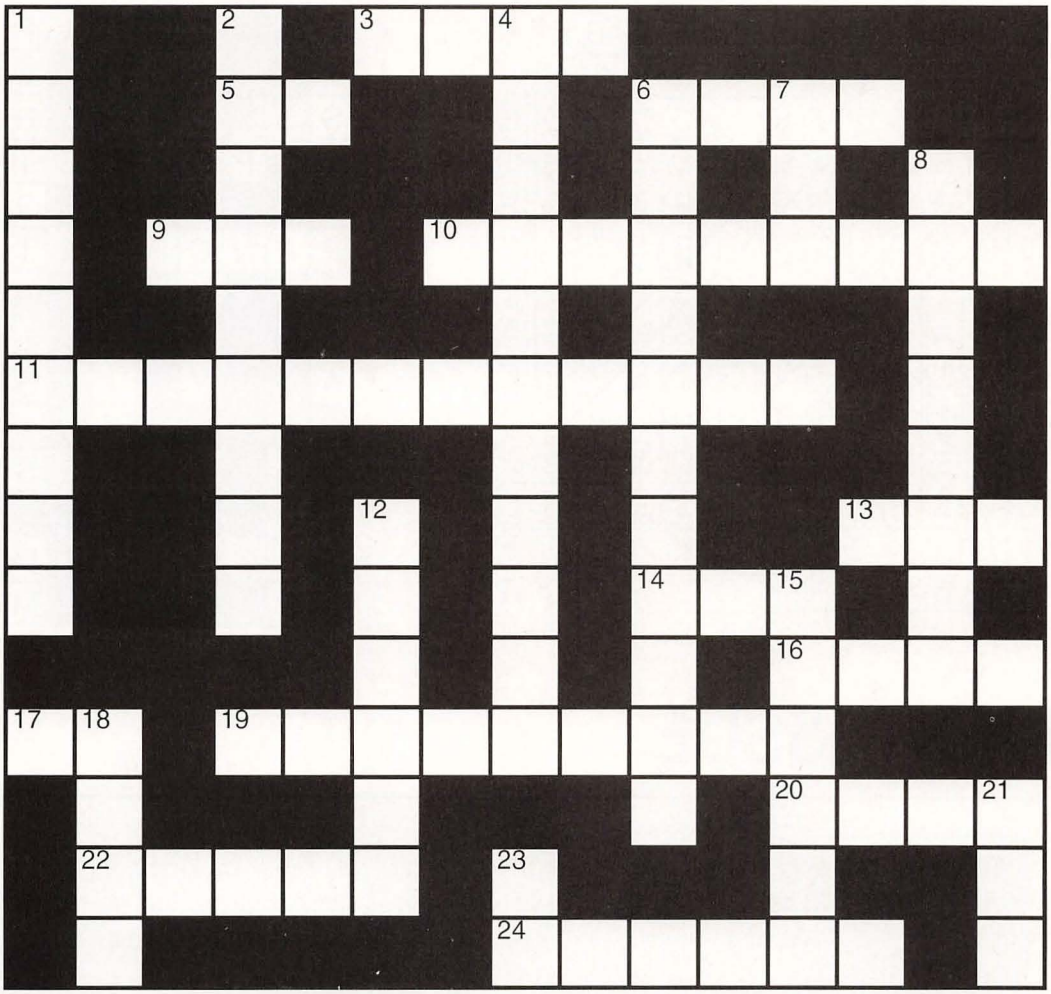
Sandie Molloy, RN, MSN

A N T I B I O T I C S L S
L S U B O G N I B U T D R
R O A I T D D O O L B I E
E P H P E E I N D T P S T
N U E O M R E N R P U L E
I M Q N C V U H E F S O H
A P T I A L J S S P H D T
C C A R N E A N S W Q G A
O E T A X H A R I E O E C
D N S P G R C S N P R L R
I T E E T A P E G X G P F
L R L H C G N I T R A H C
T A S K I L L Z H S U L F
E L D E E N W O L B Z Q J
M M C R G C Q A S P E P K

Here are 28 words used by the IV team. See how many you can find! Remember that words can be found horizontally, vertically and diagonally, and can be spelled forward or backward. Good luck! Solution on page 50.

Alcohol
Antibiotics
Asap
Blood
Blown
Catheter
Central
Charting
Dislodge
Dressing
Expert
Flowsheet
Flush
Gauze
Heparin
Intravenous
Iodine
Lidocaine
Needle
Pressure
Pump
Push
Skill
Stat
Tape
Technique
Transfuse
Tubing

JNJ CROSSWORD



GI Crossword Puzzle
by Sandie Molloy, RN, MS

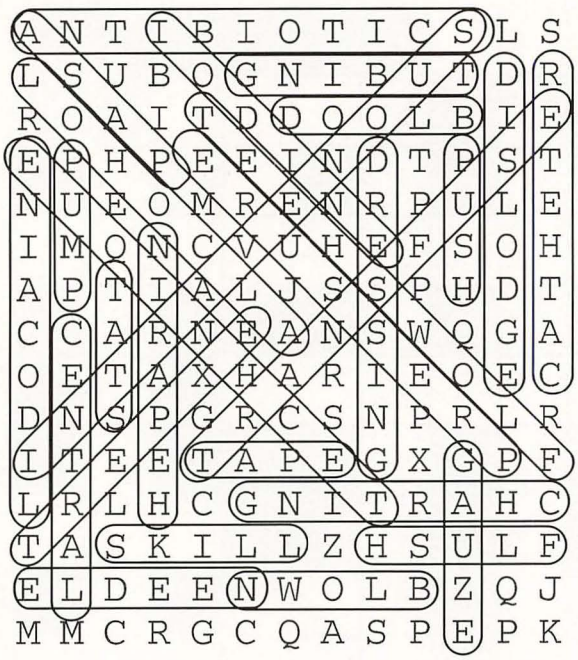
Across

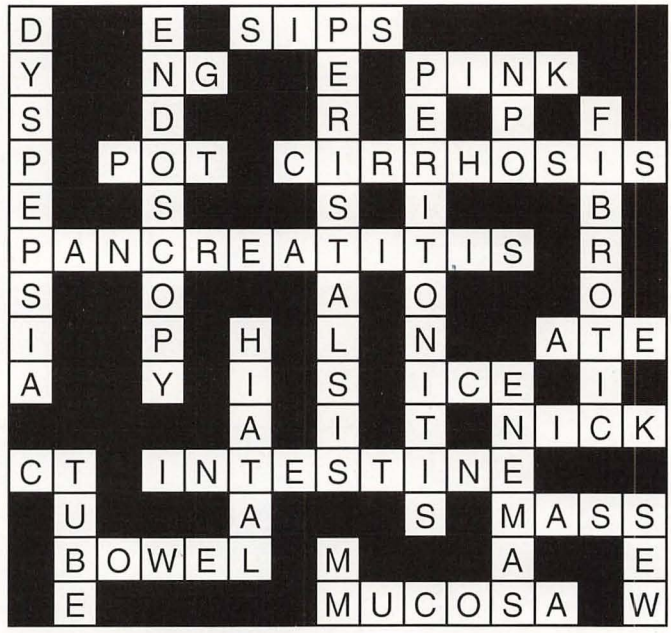
3. _____ of water
5. nasogastric (abrv)
6. color of mucosa
9. _____ belly
10. liver disease
11. pancreatic inflammation
13. consumed
14. chips of _____
16. _____ the bowel
17. computed tomography (abrv)
19. alimentary canal
20. abdominal _____
22. sounds like "vowel"
24. top layer of bowel

Down

1. upset stomach
2. look inside gut
4. motion of the intestine
6. peritoneal inflammation
7. nothing by mouth
8. fibrous in nature
12. _____ hernia
15. clears out colon
18. NG _____
21. do with sutures
23. millimeters (abrv)

Solution on page 50





NEXT ISSUE

The Future of Nursing: An Update or Half a Future is Better than None by Lois Needle, RN. "Looking for Nurses interested in management. No credentials or experience necessary." Science fiction or reality? You decide.

How to Cope with Right Sizing by Laura T. Hall, RN, MN, CNS. Has a growing patient load got you down? Here are some time-saving tools that can help you get the job done.

Doctor Types and How to Deal With Them by Christine Stephens, RN. Physician behaviors and appropriate nursing skills to apply in response.

Romantic Problems and Your EKG by Patricia Agostino, RN. Is your romantic relationship on the rocks? Are you fantasizing more about curling up with a good book instead of with him? Well, you may be experiencing heart block.

Is This a Hotel? by Holly D. Inn, RN. Compare and contrast: is there a difference between a hospital and a fine hotel?

Augmenting Consulting Physician Assessment Tool (ACPAT) by Terri Quillen, RN. Managed care strikes again: another form to fill out. And acronyms galore.

How Nursing School is Like Pregnancy by Brigid Nave, SN. When graduation day is nine months away, the mind muses analogies . . .

Classified Advertisement Translations by Edith A. West, RN, MSN. Back in the job market again? Here's the key to interpreting the jargon in classified ads.

Humor and Hostility by William F. Fry, Jr. MD. The third in a series about misconceptions that give humor a bad reputation.

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FAX (503)873-8726
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Miscellaneous

Nurses with Theater/Acting Experience Needed for Nursing Musical!
The Journal of Nursing Jocularity is making plans to present our original musical "Who's Got the Keys?" again. If you have stage experience or know someone who does, please send resume to: Who's Got the Keys, c/o JNJ, P.O. Box 40416, Mesa, AZ 85274.

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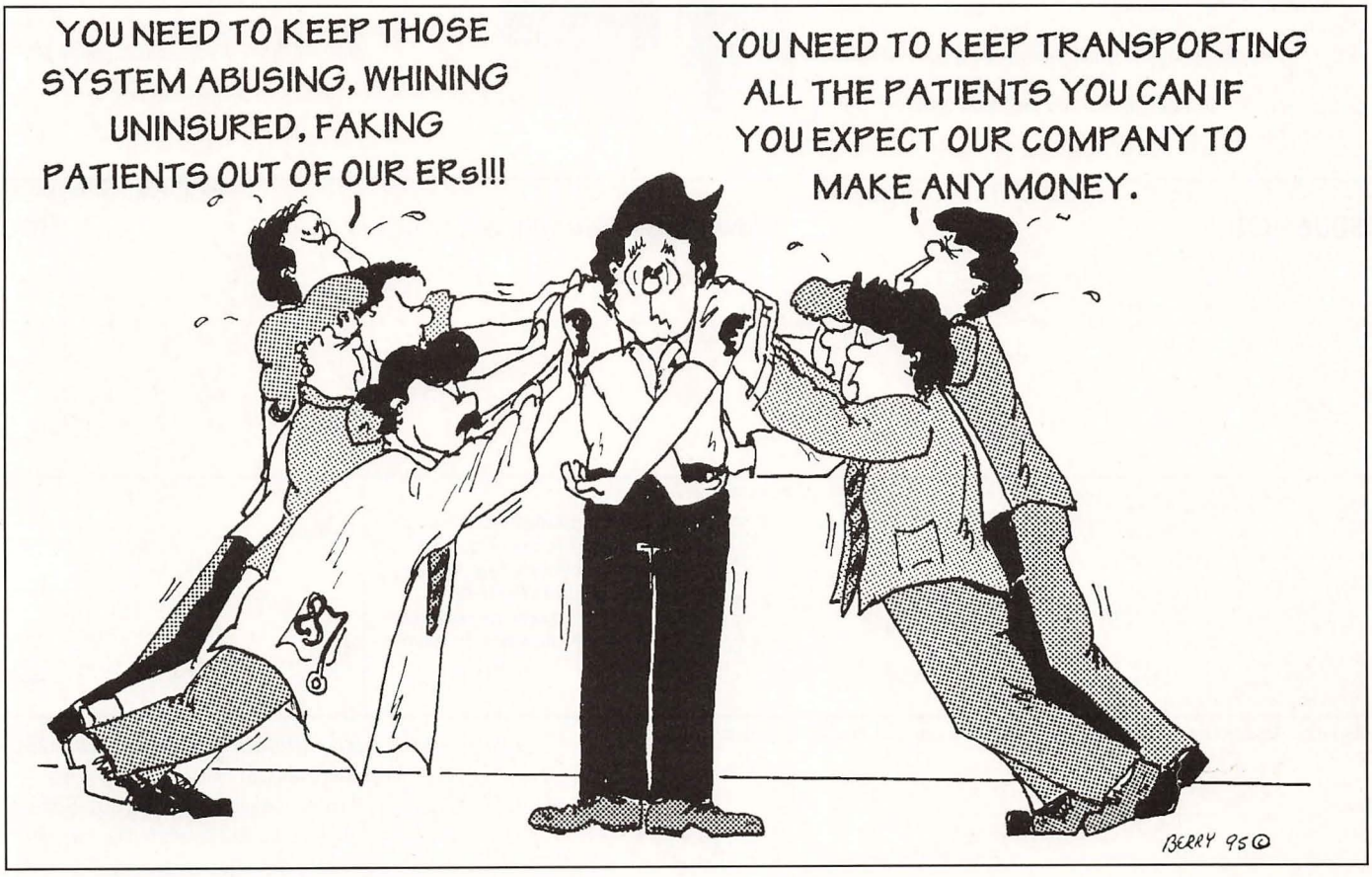
Catalogs

The Jocularity Catalog
is THE Humor Resource for Health Professionals offering such items as therapeutic humor books, rubber chickens, mugs, T shirts and much, much more! Call (602)835-6165 for your free copy or ask for one by Email, 104645.2764@compuserve. com.

STEP RIGHT UP! The Sears Drug Catalog of 1904 will cure your kidneys with asparagus, treat your addictions with opium, and may have you waxing romantic about the FDA. Perfect for a bathroom near you! $8.50 post-paid from The Animating Apothecary, 201 Arcadia Blvd, Battle Creek, MI 49017



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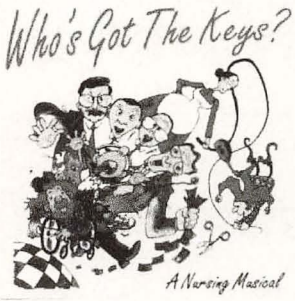

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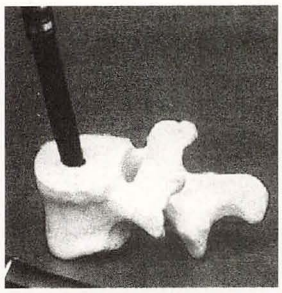
TA019WGC Keys CD $17.95
TS016WGT Keys T-shirt $16.00

Humor Magazine Collection This compilation of humor resources is a great value for anyone doing research on humor or just interested in finding sources for funny stuff! It includes one copy of each of the following: *Annals of Improbable Research, Stitches, Inside Hysteria, Funny Times, The Comedy Magazine, Journal of Polymorphous Perversity* and a *Humor and Medicine Bibliography* compiled by the Editor of *International Journal of Humor Research*. This collection is valued at over $26.00.
MS021HMC Humor Magazine Collection $13.00

Lumbar Mug Put a little backbone in your coffee with the Lumbar Mug. A fun way to drink your morning libations! Dishwasher and microwave-safe, this mug fits comfortably in your hand and holds 12 oz.
MG013LMC Lumbar Mug $10.95



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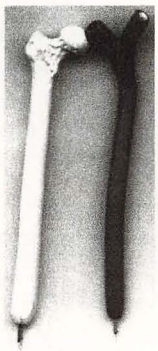

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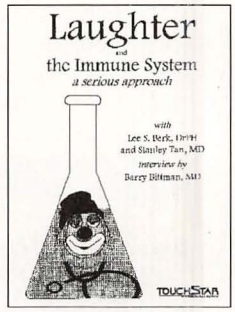
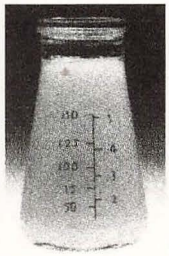
TA018LIS Laughter and the Immune System $15.95





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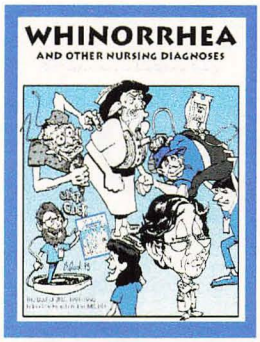

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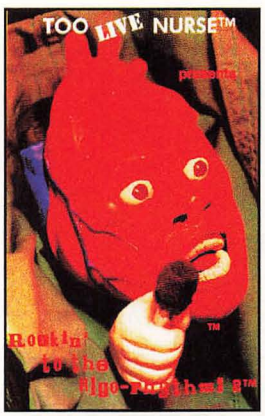

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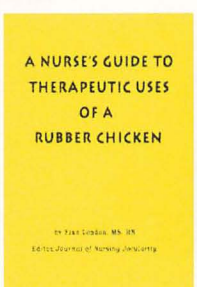

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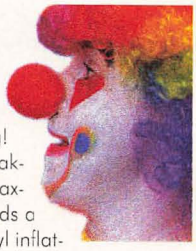

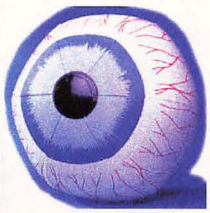

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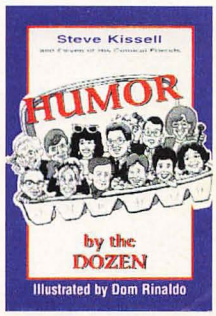
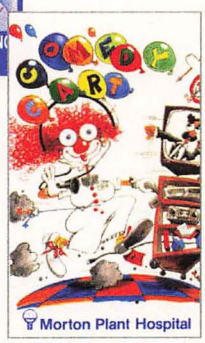
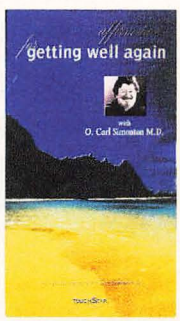


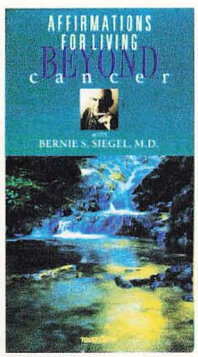
Humor by the Dozen by Steve Kissell and Eleven of his Comical Friends. Steve and eleven of his funniest comrades got together for this one! Steve's third book contains a dozen humorists, motivational speakers and down-right really funny guys and gals relating stories and one-liners! You'll be entertained a dozen times over. Paperback 159 pages. BK020HUM Humor by the Dozen $9.95



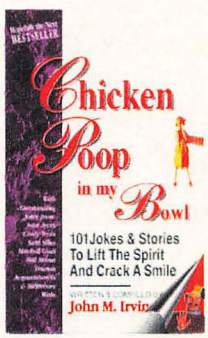
How to Create a Comedy Cart with Leslie Gibson, RN, BS. This presentation will help answer your questions on how to develop a therapeutic humor program. It is packed with information on how to prepare a budget, orientation of staff, management of supplies and obstacles to avoid. Facilitator and patient guides are included. Video 38 minutes. TA010CCC Create a Comedy Cart $50.00



Affirmations for Getting Well Again with O. Carl Simonton, M.D. Through nature's example of harmony and balance, you are about to embark upon a soul-illuminating journey for rediscovering wellness, happiness and inner peace. Your guideposts are a series of inspirational visual affirmations overlaid upon a wondrous canvas of natural scenery and complemented by a deeply moving soundtrack designed to resonate with your soul. 38 minute Video. TA015GWA Getting Well Again $24.95

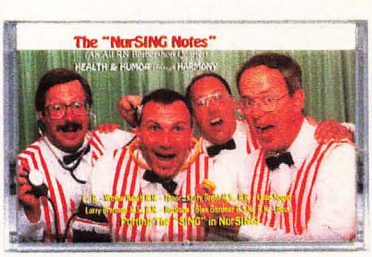


Affirmations for Living Beyond Cancer with Bernie S. Siegel, M.D. An inspirational journey of hope, love and inner peace for those who must come to terms with the unexpected challenges associated with a diagnosis of Cancer. A sensitive and creative blend of natural scenery, music and suggestions that gently guides you through a healing journey and the achievement of wellness. 30 minutes Video. TA016LBC Living Beyond Cancer $24.95



Chicken Poop in My Bowl by John M. Irvin. This book contains over 101 jokes, stories, riddles and such for almost any occasion. If you enjoy jokes, this collection is for you. *Chicken Poop...* contains some of the best humor John Irvin has found throughout the United States while delivering Hilarity Therapy® seminars. Paperback, 164 pp. BK035CPB Chicken Poop $7.95

The Nursing Serenity Prayer This spoof of the famous "Serenity Prayer" comes beautifully printed on a serene, cloud-filled background with a pink satin bow accent and framed in black and gold. The 8" x 10" prayer makes a great addition to any nurse's station. MS009NSP Serenity Prayer $9.95



Health & Humor through Harmony by the "NurSING Notes", with songs such as "While Strolling Down The Hospital Hall", "The Physician", "The Waiting Room" and "Patient Lament". Cassette tape. TA003HHH Health & Humor Through Harmony $10.00

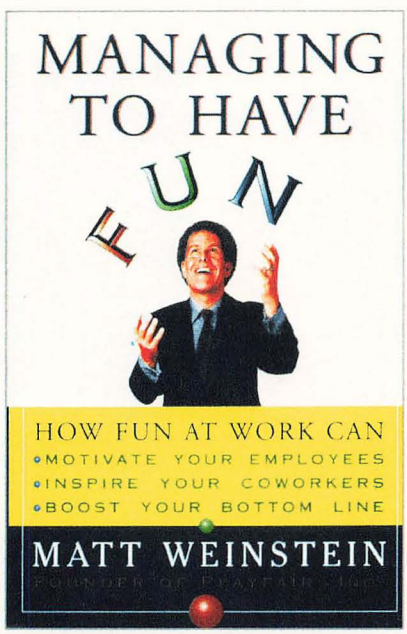
HUMOR X

by Karyn Buxman, RN, MS

I attended my first Laughter and Play conference in Clearwater, Florida back in 1990. It was then that I got my first opportunity to see Matt Weinstein at work. Teamed up with Joel Goodman, founder of the HUMOR Project, Matt took the audience of about six hundred people through a series of noncompetitive games, reminding us of the importance of play. I immediately bought their book, Playfair: Everybody's Guide to Noncompetitive Play (Impact Publishers, 1980) which has become a classic in its field. Through the years I've kept my eye on Weinstein and his whereabouts, and I was absolutely delighted to discover his latest book, Managing to Have Fun: How Fun at Work Can Motivate Your Employees, Inspire Your Coworkers, Boost Your Bottom Line (1996, Simon & Schuster, hardback, 220 pages, $21.00).

The reader discovers from the start that Matt Weinstein has a special relationship with his employees at his company, Playfair. The cornerstone of the Playfair philosophy is that "playfulness is a forgotten language that adults can easily relearn. Once we recall that feeling of jubilation that we once knew as children, we can even make work fun" (pages 12-13). The corporate motto: If you take yourself too seriously, there's an excellent chance you will wind up seriously ill!

The focus of Weinstein's company and his book is that the intentional use of fun at work can be a positive force in team building, customer service and boosting employee morale and company loyalty; but just as significant is the impact of fun on stress management and wellness on the job. How do you establish a corporate culture that values celebration, appreciation and the human side of business? Weinstein provides four principals designed to help incorporate fun and play into business life:



Principle 1: Think about the specific people involved. The better you know people in your organization, the more appropriate and effective you can be in using fun and play for reward, recognition and revitalization. Weinstein points out that people have their own style of fun, their own ideas about what's appropriate and that it's important to respect the individuals involved.

Principle 2: Lead by example. In other words, you can't ask anyone to do anything that you are personally unwilling to do. When you lead by example, this may involve taking some risks.

Principle 3: If you're not getting personal satisfaction from what you're doing, it's not worth doing. Insincere or meaningless gestures may be more detrimental than beneficial.

Principle 4: Change takes time. Sometimes it's easier to change your own attitude than it is to communicate change to people who have worked with you for a long time. It may take long-term repeated actions to bring about even subtle change in the business.

Weinstein points out that one playful, positive interaction at work can inspire the recipients to act in kind, creating a chain reaction of fun and celebration to be enjoyed by the rest of the employees in the organization. He cites a study, nicknamed "The Good Samaritan Study," where researchers observed that when we feel good, we tend to do good. In other words, if you do something nice for another person, he or she is much more likely to do something nice for someone else, causing one small gesture to result in a giant ripple effect (page 49). Weinstein shares an amusing anecdote about a friend of his who threw coins over his shoulder while they were running together one day, in hopes of influencing folks in the area to feel good and maybe even do good. (I immediately had a flashback to the first JNJ conference in Phoenix. As publisher Doug Fletcher prepared to check out of his room, he dug into his pocket, pulling out all his loose change. He then proceeded to drop the money behind the cushions of the couch in his room. As I watched in disbelief, I asked what in the world did he think he was doing? He turned and grinned from ear to ear, then responded, "Someday somebody's going to have some real fun discovering the change in this couch. Too bad we won't be here to see it, isn't it?")

If implementing fun at work is a goal for you, Weinstein believes that trying one new and fun idea on the job once a week is realistic. Therefore, he provides fifty-two strategies, one a week, for a year's worth of fun at work. Some of the ideas have to do with creating a more fun environment. Some of the strategies can be done on an individual level, while others entail company-wide involvement. Here are some of my favorites:

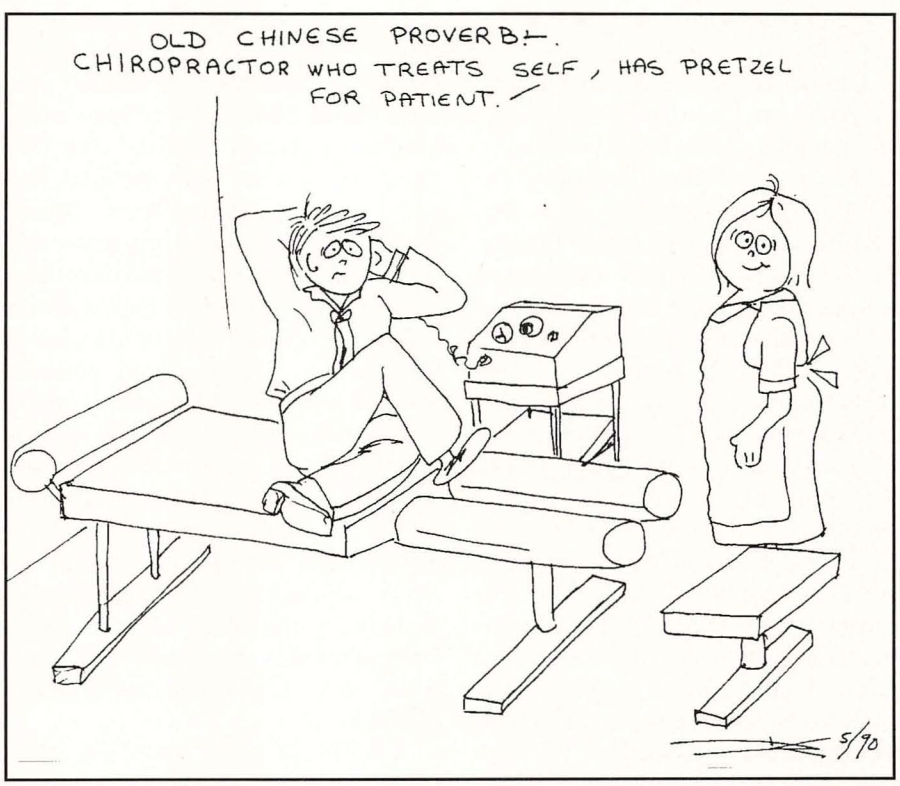
12. Give anonymous and unexpected appreciation. One of the Playfair team tears out a page from her Far Side calendar and sends it along with her check when she pays her monthly phone bill, providing an unexpected laugh to someone with a mundane job.

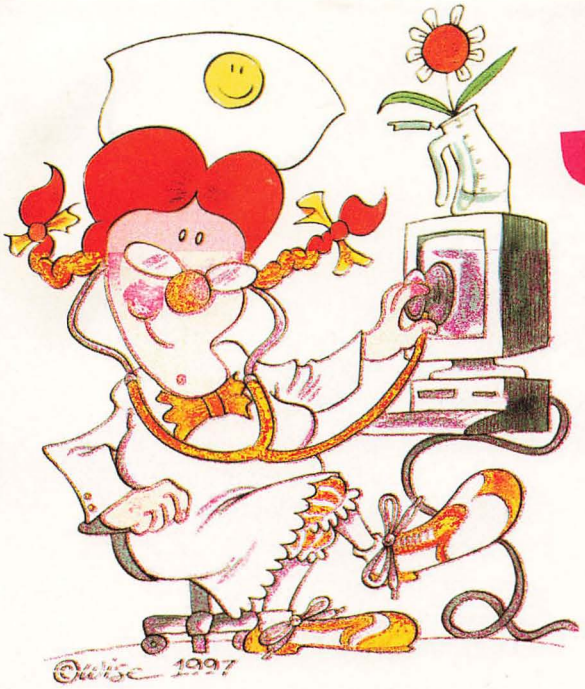
16. Lend a bouquet of flowers. Someone brought a bouquet of flowers to work with the following instructions: Keep this bouquet on your desk for the next half hour. Then pass it along as a gift to someone else and tell them to do the same thing.

43. Create a welcoming ritual. Instead of waiting until someone retires to have a party, throw a party for someone's first day at work to give the new employee an immediate sense of being part of the team and to say, "Welcome! We're glad you're here."

Weinstein says, "I like to believe that the Important Questions businesspeople will ask in the next century will not just be about productivity, quality, or reengineering. I hope one of the questions will be 'Having fun?' Because laughter and play and fun on the job can help create a culture of caring and connection in the workplace that is just as important—if not more so—than productivity and profitability. 'Having fun?' is a powerful question, because it puts the primary value on people in an organization. It is a revolutionary question to be posed in the world of business. And once we begin to ask this question of ourselves as well as of each other, then we can truly transform the way we live at work" (page 24).

I hope you manage to put more fun in your life by adding this book to your collection. Look for it at any major book store and if they don't have it, ask them to order it for you. (Now it's time for me to take a break and have some fun!) Until next time, I remain yours in laughter!





Jest for the Health of It!

by Patty Wooten, BSN, a.k.a. "Nancy Nurse"

Psychoneuroimmunology of Laughter
An Interview with Lee Berk, Dr. PH

Lee Berk, Dr. PH is a psychoneuroimmunologist, professor and medical research scientist in the School of Medicine and Public Health at Loma Linda University. He is the leader and pioneer in conducting scientific research in the psychoneuroimmunology of mirthful laughter.

Patty Wooten: *Dr. Berk could you give us a brief history and overview of your research in mirthful laughter?*

Lee Berk: Our research began back in 1983 at Loma Linda University in southern California. At that time, volumes of scientific research existed confirming that physical and psychological stress produced chemical and neurological changes. The bulk of this research focused on negative stress or distress.

Surprisingly, very few studies investigated the impact of eustress or positive emotional states. My colleague, Stanley Tan MD, PhD, and I decided to study the biochemical changes that occur relative to the eustress state of mirthful laughter. Our first study found significant changes in neuroendocrine and stress hormones in response to mirthful laughter. The next logical step was to ask, "Could we measure the impact of these neuroendocrine changes on the immune system?" After all, if, as the bible says, "A merry heart does good like a medicine," we wondered, "Would mirthful laughter stimulate any changes to the system that monitors for various pathogenic processes?"

Dr. Berk can you describe your research design and methodology?

First of all, I would like to emphasize that all of our research was scrupulously controlled for extraneous variables. We used state of the art methods to quantify measurements and employed sophisticated statistical multivariate analysis of variance (MANOVA) to interpret the results. Our subjects were medical students. The stimulus for the mirthful laughter was a videotape entitled, "Over Our Head" (pre-selected by the subjects), featuring the comedian Gallagher. Blood samples for both the experimental and control groups were gathered before, during and immediately after the video was viewed. We also collected blood samples the next day. Samples were obtained through an indwelling intravenous angiocatheter, using a stopcock and saline drip to keep the vein open. We carefully controlled for food intake, medications and exercise. All subjects were non-smokers, received no exercise the day before and the day of the experiment, and could not be taking any medication. We insured that the subjects were well rested and not physically or mentally stressed.

The control group sat in a separate room and had everything occur just as with the experimental group, except they did not view any video tape. If we had shown any other film, say a travel film, it would be possible that some subjects could have found it enjoyable or exciting while others would find it boring or distressful. By maintaining a neutral environment we avoided contaminating our data.

Dr. Berk, please explain the results of your studies and the implications they have to your hypothesis that, "A merry heart does good like a medicine."

First, we found that for the experimental group, those exposed to the humorous film, there was an increase in the number of activated T-cells (T lymphocytes). Apparently during mirthful laughter, there is a chemical stimulus that tells these lymphocytes to become active, to get prepared for combat with a potential virus, bacteria or foreign protein. Next, we saw an increase in the T-cells that had the helper/suppressor receptors or markers. Each cell in our body has numerous receptors that neurotransmitters, such as cytokines, plug into. As a consequence of these chemicals plugging into that specific receptor, the cell changes its metabolic activity.

We also saw an increase in the numbers of natural killer cells (NK cells) which are very important for immune surveillance. Natural killer cells are a type of immune cell that attack viral infected cells

and some types of cancer or tumor cells. Natural killer cells do not appear to need prior sensitization or communication to be activated. They know and recognize when another cell is aberrant or infected. Every day, cells in our body undergo a lot of change, creating potential carcinogenic cells. Fortunately, when our immune system is functioning properly, the natural killer cells destroy aberrant cells. Natural killer cells are significant in terms of immunosurveillance. Our research shows that not only does the activity of the natural killer cells increase during mirthful laughter, but the actual number of natural killer cells increases as well.

We also saw an increase in the antibody immunoglobulin A (IgA). IgA is an immunoglobulin that resides, in part, in the mucosal areas. It helps us fight upper respiratory tract insults and infections.

We also noted an increase in IgM during the intervention of mirthful laughter. IgM is the immunoglobulin or antibody, which arrives first with respect to the humoral immune response.

We also noted an increase in immunoglobulin G (IgG). The IgG takes off after the IgM does its initial work. IgG is what gives us that long-term immunity.

We also saw an increase in the number of B cells (B lymphocytes) which goes along with the immunoglobulins increasing.

In addition, we found an increase in a substance called Complement 3. This substance helps the antibodies pierce the cell open when the cell is dysfunctional or infected and needs to be disrupted or broken. Complement 3 was found to be increased both during recovery and the next day.

Our most recent research was presented at the Psychoneuroimmunology Research Society meeting in April 1996. We found significant increases in gamma interferon (IFN). The precise role of IFN in human diseases and therapy is not completely understood. However, we know that it is clearly involved in the defense against parasites, viruses and possible tumor cells. A deficiency in the production of gamma interferon has been related to persistent viral infections. Our studies showed that gamma interferon levels not only increased during the humor intervention, but also lasted into recovery and through the next day. It should be noted that plasma volume, hematocrit and total serum protein showed no significant change over these time points. It is well known that interferon plays important roles in the growth and differentiation of cytotoxic T cells, activation of natural killer cells and functions as B-cell maturation factor. Based upon this understanding, it is reasonable to propose that there indeed may be a correlative relationship at a molecular level between the presence of gamma interferon and other components of the immune system.

Dr. Berk, how might you summarize what you have discovered about the connection between laughter and health?

Essentially, we found that mirthful laughter serves to modulate specific immune system components. By modulate, we mean that chemicals released during the emotional experience of mirth can connect to receptors on the surface of the immune cells. This connection stimulates a change in the molecular machinery inside the cell. Specific molecules known as immunoregulators are like plugs that fit into receptors and subsequently increase or decrease the immune cell activity.

One metaphor for modulation of immune activity is the conductor of an orchestra. Although the conductor does not actually play an instrument, he influences the tempo, harmony and volume of the music produced by the orchestra. Mirthful laughter would be like the conductor who enhances sonic integration and brings out melodious harmony. Whereas distressful emotions would be like the conductor who brings out harsh, disharmonious sounds. Emotions, like a conductor, modulate the activity and effectiveness of the immune cells although they do not directly protect the body from insult or infection.

The results of our studies validate the existence of our eustress paradigm which links the brain, behavior and immune function in a positive manner. As a medical scientist, it is gratifying and fulfilling to continue to discover objective, scientific data to support beliefs that many have held intuitively for centuries. "A merry heart does good like a medicine." (Proverbs 17:22)

Now you listen to me young lady! If I get one more phone call from you nurses – I'm going to come over to that hospital and take care of the patient myself!!!

Winner from our last issue. We had 126 captions submitted

Punchline Puzzler

I ripped this out of the guy in 312. He was really pissing me off!

Winning caption by
Heather Robson
Sauet Ste. Marie, ON

Runner-up captions

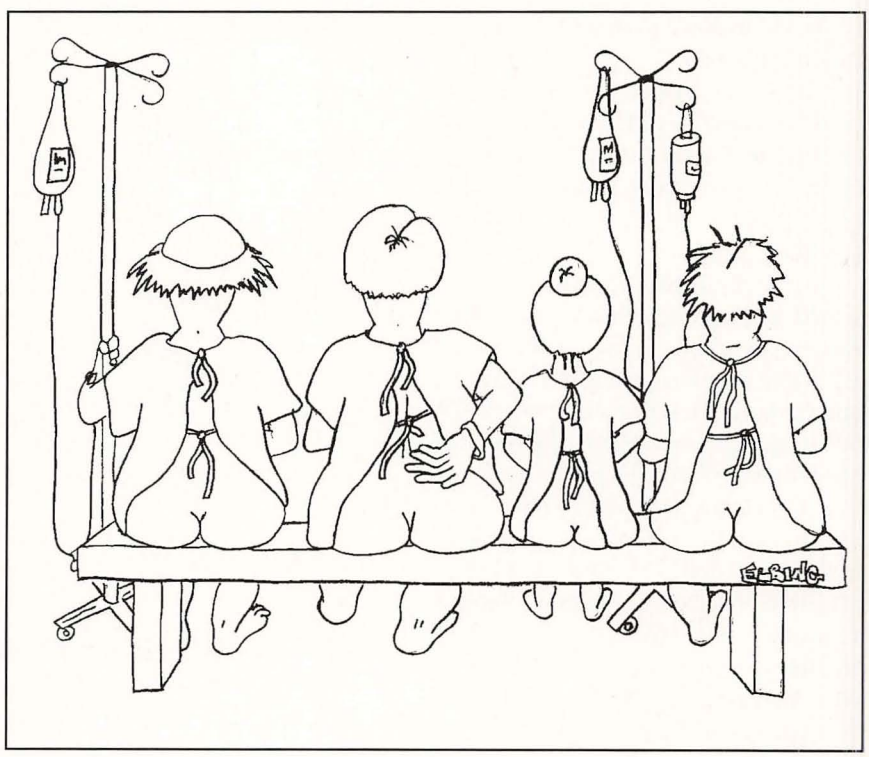
No wonder I couldn't get my underwear on straight!
Kathi Bennett
Granville, NY

I told Dr. Foley after 14 children I can't keep one of these things in.
Karen Perry, RN, CEN, CCRN
Stone Mountain, GA

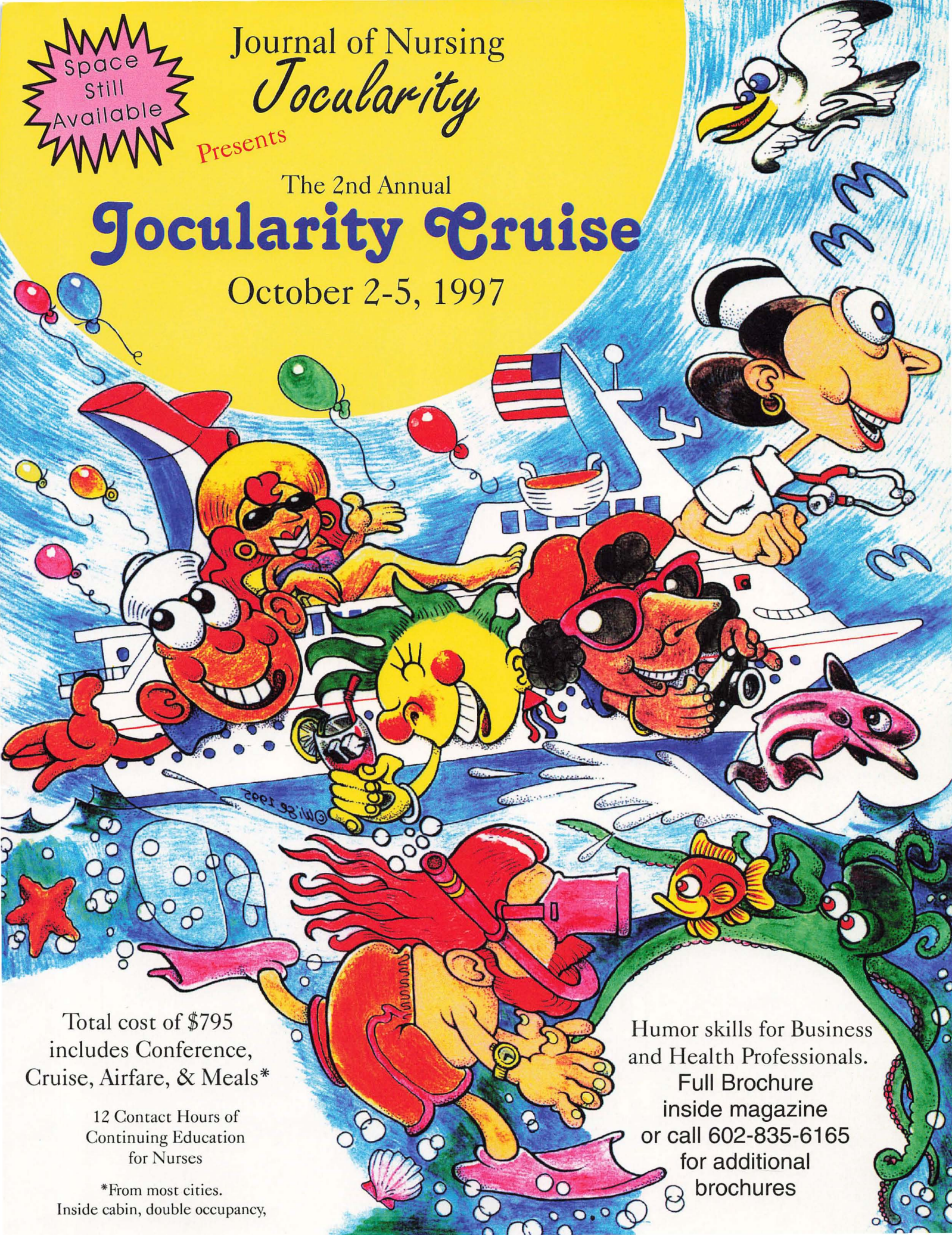
Honorable Mention

Damn — Everything goes limp in my hands!
Frank Tamaszewski
Clinton Township, MI

This cartoon needs a punchline. The Journal of Nursing Jocularity will award $25 and a JNJ T-shirt for the best caption. Two runners-up will receive a JNJ T-shirt. Send your entry on a postcard to: JNJ - Punchline, P.O. Box 40416, Mesa, AZ 85274. Entries must be received by September 30, 1997.



Special Thanks to Bobbie, Vickie, Diana, Barbara, Sharon, Janet and Bonnie of the Red Robin Judging Committee.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